

COUNTY COUNCIL OF THE WEST RIDING OF YORKSHIRE



Sixty-seventh
ANNUAL REPORT
OF THE
COUNTY MEDICAL OFFICER

AND

Forty-eighth
ANNUAL REPORT
OF THE
**PRINCIPAL SCHOOL MEDICAL
OFFICER**

YEAR 1955

WEST RIDING HEALTH COMMITTEE

(as at 31.12.55)

CHAIRMAN

County Alderman N. Carter

VICE-CHAIRMAN

County Alderman J. W. Trickett

COUNTY ALDERMEN

Bambridge, H. J., O.B.E.
(Chairman of the County Council).
 Bednall, A.
 Hudson, Major J. H., C.B.E., M.C.
(Vice-Chairman of the County Council).

Hunter, Major J. C., M.C.
 Roberts, B.
 Runton, Mrs. Ryder, C.B.E.
 Smith, Mrs. E. E.
 Sutcliffe, H.

Thackray, C., B.A.
 Whittock, M.

COUNTY COUNCILLORS

Atkinson, D. W.
 Atkinson, J. W., M.M.
 Baynham, T.
 Blackburn, J., O.B.E.
 Cheetham, T.
 Clarney, H.
 Cockroft, H.
 Crockatt, D. A.
 Cutts, W.
 Dawson, T. S., B.E.M.
 Denton, Mrs. N.
 Fortune, Mrs. N.
 Guy, H.

Hanson, G. M.
 Hardaker, Mrs. L.
 Hardy, J.
 Holt, R. B.
 Illingworth, W. H.
 Isles, F. B.
 Keers, Mrs. S. E.
 Mellor, J. W.
 Metcalf, W. E.
 Middleton, Mrs. M. D.
 Miles, H.
 Morris, W. A.
 Ogilvy, Dr. W. A.

Oldham, J. F.
 Pickersgill, A.
 Pike, Miss I. M. P.
 Rankin, H.
 Rhodes, Miss M. E.
 Smith, J.
 Stephens, Dr. J. A.
 Sutcliffe, H. H.
 Tennant, J. S., M.A.
 Thompson, M., B.E.M.
 Waddilove, G.
 Yorke, J.

WEST RIDING EDUCATION COMMITTEE

(as at 31.12.55)

CHAIRMAN

County Alderman J. Fuller Smith

VICE-CHAIRMAN

County Alderman W. M. Hyman

Representative Members:—

COUNTY ALDERMEN

Bambridge, H. J., O.B.E.
(Chairman of the County Council).
 Creighton, M.
 Flavell, A.

Hudson, Major J. H., C.B.E., M.C.
(Vice-Chairman of the County Council).
 King, W.
 Lane, J. W., B.E.M.

Runton, Mrs. Ryder, C.B.E.
(Chairman of the Finance Committee).
 Smith, Mrs. J.
 Taylor, E., M.B.E.
 Thackray, C., B.A.

COUNTY COUNCILLORS

Anson, C. E.
 Bennett, H. V.
 Boland, C. W.
 Broughton, C. T.
 Clegg, A. H.
 Craven, A.
 Crowther, A. C.
 Derbyshire, S.
 Dews, C.

England, Mrs. E. L., B.E.M.
 Fitton, Mrs. C.
 Fitzpatrick, Mrs. L. I.
 Fortune, Mrs. N.
 Geldard, Col. N., D.S.O., M.C.
 Green, Mrs. H. E., B.A.
 Hardaker, Mrs. L.
 Martinson, J.
 Morton, F.

Nicholson, G. H.
 Payne, J. E.
 Ratcliffe, Mrs. E.
 Rhodes, J.
 Smith, H.
 Stott, S.
 Tomlinson, Sir Thomas, B.E.M.
 Whitehead, H.
 Wright, G., M.B.E.

Added Members:—

Adshead, H. J.
 Martin, Mrs. M., LL.B. /
 Morris, Sir Charles, M.A.

Newsome, T. A., B.E.M.
 Priestley, R. E.
 Rowe, Miss W. E. M.
 Semmens, Mrs. H. W.

White, Mrs. D. M., B.A.
 Whittaker, Dr. J. M., F.R.S.
 1 Vacancy

STANDING SUB-COMMITTEES OF THE WEST RIDING HEALTH COMMITTEE

Ambulance Sub-Committee.—All matters relating to the County Ambulance Service. (Section 27, National Health Service Act, 1946.)

Public Health Sub-Committee.—Matters relating to the Pharmacy and Poisons Act, 1933; Housing (Rural Workers) Acts, 1926 and 1942; Housing Act, 1936; Rural Water Supplies and Sewerage Acts, 1944-55; Nurses' Acts, 1943-45; Vaccination and Immunisation (Section 26), Venereal Diseases, Public Health Propaganda (Section 28), under the National Health Service Act, 1946; Food and Drugs Acts, 1938-50; Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949-53; Shops Act, 1950; and all other powers and duties of the Health Authority not delegated to another Standing Sub-Committee.

Mental Health Sub-Committee.—All matters relating to the duties of the Local Health Authority under the Lunacy and Mental Treatment Acts and the Mental Deficiency Acts, and the care and after-care of persons suffering from mental illness or mental defectiveness. (Sections 28 and 51, National Health Service Act, 1946.)

Welfare Sub-Committee.—Arrangements for the prevention of illness, the care of persons suffering from illness other than mental illness, or the after-care of such persons. (Section 28, National Health Service Act, 1946, and the Public Health (Tuberculosis) Regulations, 1952.)

Arrangements for promoting the welfare of persons who are blind, deaf or dumb and other persons who are substantially and permanently handicapped by illness, injury, or congenital deformity, or such other disabilities as may be prescribed by the Minister of Health, and arrangements with Voluntary Organisations therefor. (Sections 29 and 30, National Assistance Act, 1948.)

Assistance grants to voluntary organisations providing meals or recreational facilities for old people. (Section 31, National Assistance Act, 1948.)

Arrangements for the protection of property of persons admitted to hospitals etc. (Section 48, National Assistance Act, 1948.)

The recovery of charges and expenses where permissible in respect of all services provided by the Health Committee.

The West Riding Distress Fund.

Welfare Accommodation Sub-Committee.—The provision and management of residential accommodation for persons who, by reason of age, infirmity or any other circumstances, are in need of care and attention which is not otherwise available to them. (Sections 21-24, National Assistance Act, 1948.)

Arrangements with Voluntary Organisations and other Local Authorities for the provision of accommodation in property maintained by them. (Section 26, National Assistance Act, 1948.)

The registration of disabled persons or aged persons homes. (Sections 37-39, National Assistance Act, 1948.)

Registration of charities for disabled persons. (Section 41, National Assistance Act, 1948.)

Care of Mothers and Young Children and Nursing Services Sub-Committee.—The duties of the County Council in respect of Nursing Homes (Sections 187-194) and Notification of Births (Section 203), under the Public Health Act, 1936; the care of mothers and young children (Section 22), domiciliary midwifery (Section 23), health visiting (Section 24), home nursing (Section 25) and domestic help (Section 29) services under the National Health Service Act, 1946; the Nursery and Child Minders Regulation Act, 1948; and the Midwives Act, 1951.

JOINT STANDING SUB-COMMITTEE OF THE WEST RIDING HEALTH AND EDUCATION COMMITTEES

Divisional, School Health and Dental Services Sub-Committee.—All matters appertaining to the Divisional Health Administration (Section 111, Local Government Act, 1933); and the School Health and County Dental Services. (Education Act, 1944.)

STANDING SUB-COMMITTEE OF THE WEST RIDING EDUCATION COMMITTEE

Special Services Sub-Committee.—All matters appertaining to the ascertainment of handicapped pupils and the provision of special educational treatment. (Education Act, 1944.)

SUMMARY OF CONTENTS

		<i>Page</i>
Part I	Vital Statistics - - - - -	7 — 19
Part II	Epidemiology - - - - -	20 — 37
Part III	Divisional Administration - - - - -	38 — 43
Part IV	National Health Service Acts—	
	Section 21. Health Centres - - - - -	45
	Section 22. Care of Mothers and Young Children - - -	45 — 51
	Section 23. Midwifery - - - - -	52 — 55
	Section 24. Health Visiting - - - - -	55 — 57
	Section 25. Home Nursing - - - - -	57 — 59
	Section 26. Vaccination and Immunisation - - -	59
	Section 27. Ambulance Services - - - - -	60
	Section 28. Prevention of Illness, Care and After-Care - -	60 — 73
	Section 29. Domestic Help - - - - -	73 — 75
	Section 31. Mental Health - - - - -	76 — 83
Part V	Environmental Hygiene - - - - -	84 — 104
Part VI	Other Services - - - - -	105 — 110
Part VII	The Health of the School Child—	
	Report of the Principal School Medical Officer - - -	111 — 141
	Report of the Principal School Dental Officer - - -	130 — 132
Appendix 1	List of Clinics - - - - -	142 — 164
Appendix 2	List of Staff - - - - -	165 — 168
Index	- - - - -	169 — 170

To the Chairman and Members of the Health Committee.

Mr. Chairman, Ladies and Gentlemen,

I have the honour to present the Annual Report on the public health and preventive medical services in the West Riding Administrative Area for the year 1955.

As last year the Report is on general lines and follows the form prescribed by the Ministry of Health in Circular 17/55 dated the 23rd November, 1955.

Three minor changes have been made in the lay-out of the Report this year which will be seen from the summary of contents. First, the various services provided under the National Health Service Acts have been grouped together in one Part and the sections of the Acts under which the service is provided appear as sub-headings. Secondly, a new Part has been provided under the heading Divisional Administration as it is thought desirable to publish again the scheme for divisional administration of the Preventive Medical Services with amendments and developments which have taken place since its inception. Lastly, the School Health Report embodying the Principal School Dental Officer's Report and the Report of the Divisional School Medical Officer for the excepted District of Keighley has now been placed at the end of the main body of the Report. It is hoped that these three changes will make for easier reference.

The vital statistics of the County Administrative Area are again satisfactory. The live birth rate has increased from 15.1 per 1,000 estimated population to 15.3, and the death rate from all causes has dropped from 11.9 to 11.7 per 1,000 estimated population. In the case of tuberculosis new low figures have been achieved both in deaths from tuberculosis of the lungs and from other tuberculous disease. These record low figures are respectively 0.11 and 0.01 per 1,000 estimated population: in 1930 these rates were 0.57 and 0.20. Particular pleasure is evinced in recording that the infant mortality rate has now dropped to 26.2 per 1,000 live births which is the lowest on record, and the neo-natal mortality rate has decreased to 17.4, also the lowest recorded.

For the first year ever there was no confirmed case of diphtheria in the Administrative County. The fall in the incidence of this disease has been dramatic for only twenty years ago there were over three thousand corrected notifications and the attainment of perfection in such a short time is certainly worthy of comment. The fact that diphtheria is now a rare disease does detract parents from the need to maintain a high level of immunisation in the child population, particularly in infants under one year old, but to keep this disease in check immunisation must be continued and should be in the forefront of the thoughts of all who consider the welfare of children.

Another disease which can be kept under control by preventive measures is smallpox. No case of this dreaded disease occurred during the year. An appeal was made during 1955 for an increase in the number of vaccinations of children under one year of age and, as is recorded in the body of the Report, the co-operation of family doctors was sought with undoubted useful result. That the number of primary and re-vaccinations is still not sufficient is due in large measure to the apathy of the adult population in the years when the County is free from outbreaks of smallpox.

That problems in preventive medicine are always with us is emphasised by the outbreaks of poliomyelitis and dysentery which occurred during the year. General measures for the control of both these diseases depend on the basic principles of personal hygiene, namely cleanliness, avoidance of unnecessary crowds and strict control of food handlers. The confirmed cases of poliomyelitis numbered 330, of which 244 were of the paralytic form, and this total was the highest since 1947. A full account of the prevalence of poliomyelitis during 1955 will be found in the Report with special reports from four Divisional Medical Officers. Mention is also made of the proposal of the Ministry of Health to make available a vaccine during 1956, thus a further step is being taken towards the conquest of this disease.

Notifications of dysentery continued at a high level, in fact the total for 1955 was only exceeded by the number for 1954. There is no doubt that this disease is more prevalent even allowing for more interest being taken in it, and as a result more notifications being made. Special reports from two Divisional Medical Officers on outbreaks in their divisions will be found in the Report.

Last year I was able to report that a survey had been made of premises used for clinic purposes and a comprehensive scheme approved for the building of clinics of three different sizes to serve the needs of varying centres of population. A multiple clinic, the largest type and the first to be built under the scheme was opened during the year at Morley, while a medium sized type neared completion at Hemsworth and will be in use during 1956. Unfortunately, the scheme for new clinics received a set-back early in 1956 by the receipt of Ministry of Health Circular 3/56, which placed severe restrictions on capital expenditure by local authorities. There will consequently be a delay in the building of new clinics as these are not considered to be among the most urgent needs.

Increasing attention has been paid in recent years to the importance of diet to promote health and particularly to prevent pre-eclamptic toxæmia in pregnancy. This has been the subject of special lectures to all public health nursing staff to ensure that suitable advice can be given to the expectant mothers, and others, who may come under their care: reference to the work is made on page 57 of the Report.

Last year attention was drawn to the difficulties of providing training for mental defectives in a large County area. Use is made of centres provided by County Boroughs within or adjacent to the West Riding geographical County, but this is not sufficient and the need to augment the number of centres owned by the County Council is urgent. Fortunately, occupation centres do not come under the restriction on capital expenditure to the same extent as infant welfare clinics, and it is hoped to continue with a modified building programme. During the year the new occupation centre at Hemsworth was completed and brought into use in September. An elevation and plan of the centre will be found on page 83. In addition to the new centre, adaptations of four existing buildings are proceeding. Pending the provision of more occupation centres, either by new buildings or by adaptations, group training classes are providing some training for mental defectives. The waiting list for admission of defectives to institutional care was 179 compared with 247 at the end of 1954.

The Standing Sub-Committee on Co-operation between the Executive Council and the Local Health Authority formed early last year, has continued to meet with success and should increase in usefulness. It is composed of General Practitioners representing the Executive Council and representatives of the County Medical Staff, thus matters of common interest can be discussed, views exchanged and solutions sought and usually found to problems which are the concern of both parties engaged in the domiciliary services under the National Health Service Acts.

The number of Divisions under the Authority's scheme for the Divisional Administration of the Preventive Medical Services at the end of the year was 28. An amalgamation previously approved was put into operation as from the 1st July, 1955, when accommodation became available for the combined office. Two further amendments of the scheme were under consideration at the end of the year. It is known, however, at the time of writing that one of these will not be proceeded with at the moment.

An Order was made under the Food and Drugs (Milk, Dairies and Artificial Cream) Act, 1950, during the year, declaring further parts of the County to be specified areas. This restricts the retail sale of milk for human consumption to that which is pasteurised, sterilised or tuberculin tested. As a result of the Order which has been made there are now (or will be shortly), 29 County Districts in specified areas, the population affected being approximately one third of the Administrative County. The declaration of new specified areas means that the County Sanitary Inspectors are involved in many inquiries and investigations before the appointed date and in these they receive willing assistance and co-operation from the local Sanitary Inspectors. Supervision in the specified areas has to be maintained after the coming into operation of the Order. During the year, a firm of milk distributors was charged with offences under this Act and was convicted and fined.

The Home Help Service continued to be in great demand and there was no difficulty in using the full establishment of 700 which had been approved from the 1st April, 1954. An account of this Service will be found on page 73 together with a graph showing the percentage employment of Home Helps on the aged in each Division. The chronic sick and the aged group absorbed 81½ per cent. of the total hours available.

In conclusion I again acknowledge my indebtedness to officers of other Departments of the County Council for their friendly and unfailing co-operation, and to all members of the staff of the County Health Department for their loyal and faithful assistance.

I am,

Yours faithfully,

J. WOOD-WILSON.

County Medical Officer.

PART I

VITAL STATISTICS

Area and Population

	Municipal Boroughs and Urban Districts	Rural Districts	Adminis- trative County
Area (acres) — See note below.....	380,328	1,229,431	1,609,759
Population:			
Census, 1931.....	1,128,519	375,538	1,504,057
Census, 1951.....	1,161,588	427,530	1,589,118
Estimated (Mid-1955).....	1,167,000	443,300	1,610,300

A slight adjustment in the boundary between Shipley U.D. and Bradford C.B. took place on 1st April, 1955. The area involved, less than 1 acre, included no population and was added to Shipley U.D. The area of the Administrative County, to the nearest acre, remains unchanged.

Number of Municipal Boroughs, 13; Urban Districts, 55; Rural Districts, 21; Total 89.

Physical Features

The West Riding is the largest of the three Ridings into which the geographical County of Yorkshire is divided and roughly forms a parallelogram about twice as long as it is broad, about 80 by 40 miles, set with its corners to the four points of the compass. The Administrative County covers some 1,609,759 acres and has a population of 1,610,300 and is bounded by the counties of Westmorland, Lancashire, Cheshire, Derbyshire, Nottinghamshire and Lincolnshire and the North and East Ridings of Yorkshire.

The principal physical feature is the Pennine range of hills running north-west and south-east which divides the Riding into two main drainage areas. On the western side of this range, in the northern area, are the river basins of the Lune and Ribble, and southwards, the upper reaches of the Mersey and Irwell Rivers. These drain a considerable area and discharge into the Irish Sea. In this area below Sedbergh are the highest points in the Riding, Whernside, 2,414, Ingleborough, 2,373 and Penyghent, 2,273 feet, the focus of the Craven District which, with the Yorkshire Dales, provide some of the most attractive scenery in England.

On the eastern side of the range the rivers flow generally in an easterly direction to the River Ouse; there are seven river basins, the most northerly being the Ure, then the Nidd, Wharfe, Aire, Calder and Don which, together with the Ouse, drain about 2,000 square miles. All these discharge towards the eastern corner of the so-called parallelogram, where the Ouse joins the River Trent to form the River Humber.

Geographically the West Riding may be divided into four main areas: the limestone hills and fells of the north-west which provide abundant pasture for sheep and cattle; in the south-west the rivers of the Pennines supply the water necessary to the textile manufacturing districts; in the north-east farming land, mainly arable, extends into the Vale of York and in the south-east are to be found the coal measures which continue into Derbyshire and Nottinghamshire.

These features have determined the industrial pattern of the Riding, with agriculture dominant in the north, and textile manufacture, coal-mining and engineering in the south. Because of this differentiation, the 13 non-County Boroughs, 55 Urban Districts and 21 Rural Districts of the Administrative County differ widely in size, population, physical and sociological characteristics. For example, of the non-County Boroughs, at one end of the scale Keighley, long renowned as a centre of textile engineering, has an acreage of 23,611 and a population of 55,720, whereas Ripon City, a market town in the agricultural belt, has only 1,812 acres and 10,030 population. Again, Urban Districts vary from Shipley with its textile and manufacturing industries and 32,470 people to its neighbour Denholme with only 2,600 and the mainly agricultural district of Tickhill which is on the fringe of the South Yorkshire coalfield with a population of 2,560. Rural Districts also offer a wide variation, for Sedbergh with its 52,674 acres has far more sheep grazing on the moors, hills and fells than its population of 3,800 as compared with Doncaster Rural's 75,092 acres supporting 55,590 people who are occupied substantially in mining and other industrial occupations.

The West Riding may have many broad acres with picturesque landscapes but it has also been described as one of the busiest and most prosperous industrial areas in Britain; and the foregoing should be borne in mind when making statistical comparisons between County Districts in the Riding.

Summary for 1955

The live birth rate was 15.3; the stillbirth rate per 1,000 live and still births 26; the live premature birth rate per 100 live births 7.2. The death rate from all causes was 11.7; diphtheria nil; whooping cough 0.002; measles 0.002; meningococcal infections (cerebro-spinal or spotted fever etc.) 0.01; acute poliomyelitis 0.004; tuberculosis of the lungs (respiratory system) 0.11; other forms of tuberculosis 0.01; respiratory diseases 1.17; cancer 1.90; heart and circulatory diseases 4.39 per 1,000 population. Infant mortality was 26 and maternal mortality 0.67 per 1,000 live and still births.

A comparison of the figures for the past 66 years is given in the following table:—

Year	Live Birth Rate	Death Rate All Causes	Zymotic Death Rate	Tuberculosis of lungs Death Rate	Other Tuberculous Diseases Death Rate	Respiratory Diseases Death Rate	Cancer Death Rate	Stillbirths per 1,000 total births	Maternal Mortality per 1,000 total births	Infant Mortality
1890–1909	28.9	16.7	1.89	1.19	0.52*	3.20	0.77*	†	†	147
1910–1919	22.5	14.5	1.26	0.84	0.41	2.58	0.98	†	†	112
1920–1929	20.2	12.4	0.56	0.68	0.25	2.08	1.20	†	†	82
1930	16.9	11.4	0.33	0.57	0.20	1.35	1.33	45	5.96	65
1931	16.1	12.4	0.38	0.57	0.16	1.64	1.32	45	5.56	74
1932	15.8	12.1	0.39	0.52	0.17	1.33	1.46	48	4.97	70
1933	15.0	12.2	0.30	0.49	0.14	1.36	1.42	47	5.94	70
1934	15.2	11.7	0.41	0.44	0.12	1.16	1.44	48	5.53	58
1935	15.0	11.9	0.28	0.48	0.10	1.13	1.48	47	4.34	58
1936	15.1	12.3	0.29	0.44	0.12	1.25	1.51	45	4.16	63
1937	15.2	12.7	0.21	0.46	0.11	1.23	1.60	45	3.74	60
1938	15.5	11.6	0.23	0.38	0.11	0.99	1.55	44	3.58	51
1939	15.2	12.2	0.18	0.41	0.10	1.01	1.52	42	2.92	54
1940	15.3	13.4	0.18	0.42	0.11	1.94	1.58	40	3.13	56
1941	15.4	12.3	0.22	0.42	0.12	1.43	1.68	39	2.61	57
1942	17.0	11.7	0.18	0.42	0.12	1.26	1.65	36	3.23	49
1943	17.8	12.7	0.19	0.43	0.12	1.63	1.72	34	2.40	50
1944	20.2	12.1	0.12	0.37	0.09	1.32	1.79	31	1.92	44
1945	17.9	12.3	0.19	0.38	0.09	1.36	1.80	30	1.73	51
1946	19.7	11.9	0.13	0.36	0.08	1.31	1.72	29	1.80	44
1947	21.5	12.3	0.16	0.39	0.09	1.37	1.80	26	1.28	45
1948	18.5	11.3	0.12	0.37	0.07	1.29	1.74	24	1.15	39
1949	17.2	12.1	0.08	0.32	0.05	1.44	1.81	24	0.83	38
1950	16.3	11.8	0.10	0.25	0.04	1.18	1.83	24	0.98	35
1951	15.8	12.7	0.10	0.24	0.04	1.48	1.80	26	0.93	32
1952	15.4	11.5	0.07	0.16	0.03	1.11	1.92	25	0.80	30
1953	15.7	11.6	0.08	0.16	0.02	1.20	1.88	25	0.51	29
1954	15.1	11.9	0.08	0.16	0.02	1.16	2.01	26	0.89	28
1955	15.3	11.7	0.07	0.11	0.01	1.17	1.90	26	0.67	26

* This rate is for the 10 years 1900–1909.

† Figures not available.

In the above table, the birth and death rates are per 1,000 estimated population; the stillbirth and the maternal mortality rates are per 1,000 total births (i.e., per 1,000 live plus stillbirths); the infant mortality rates are per 1,000 live births.

The incidence of, and the mortality from smallpox, enteric fever including paratyphoid fever, scarlet fever, diphtheria, measles, whooping cough, and diarrhoea in infants under two years of age was formerly considerably more than those of other infectious diseases. They were thus classified as the seven principal zymotic or infectious diseases, and it was customary to give a combined death rate therefrom denominated the “zymotic diseases death rate”, or the “zymotic death rate”. The zymotic death rates shown above are on this basis up to and including that for the year 1949. The mortality from all of these seven diseases has declined considerably and in some cases is now below that of some infectious diseases not included in the classification. Therefore, the combined mortality from the zymotic or infectious diseases is now best shown by a combined death rate from infective and parasitic diseases excluding tuberculosis, influenza, acute primary and influenzal pneumonia, enteritis and certain localised infections. The rates from and including 1950 are shown on this new basis.

The respiratory diseases death rate is the combined death rate from bronchitis, pneumonia, and other respiratory diseases excluding tuberculosis and influenza.

Births and Infant Mortality

The number of live births registered during the year was 24,601 (12,662 males, 11,939 females) being slightly higher than that for 1954 and representing a crude rate of 15.3 per thousand population compared with 15.1 in 1954 and 15.5 in 1938. Although these rates have some similarity, in the intervening years the rate fluctuated widely, but it would now appear to have reached relative stability at a slightly higher level than pre-war.

Illegitimate births numbered 905 in 1955 as compared with 881 in 1954 and, while the resultant rate per thousand total live births has increased from 36 to 37, it compares favourably with the average for the five preceding years of 39. The ratio of legitimate to illegitimate births has increased in recent years; in 1946 for 17 children born one was illegitimate whereas in 1955 for every 27 children born one was illegitimate.

The excess of births over deaths (natural increase of the population) was 5,714 in 1955 compared with 5,085 in the previous year and 5,971 for the average of the five years 1950-54. Now that the fall in the birth rate would appear to have been arrested, with the rate fluctuating only a point or two from year to year, in view of the higher mortality likely to result from the ageing population it is inevitable that the natural increase must shortly tend to diminish.

The number of stillbirths assigned to the Administrative County in 1955 was 666 compared with 642 in 1954 and corresponding to a rate per 1,000 live and still births of 26.4 and 25.9 respectively. Although the rate is slightly lower than that for ten years ago the lack of progress in reducing the rate is disappointing. The loss of a child's life by stillbirth is just as much a tragedy as the loss of a liveborn infant and increased efforts are required to reduce the number of stillbirths which are occurring.

Progress continues to be made in the reduction of infant deaths. In 1955, 645 infants under one year of age died, the rate per thousand live births being 26.2 and it is pleasing to be able to state for the eighth year in succession that this is the lowest infant death rate ever recorded for the Administrative County. A rate of this level seemed almost an ideal of attainment twenty years ago when the figure was around 60. It is, however, higher than the rate for England and Wales, namely 24.9 and there is still room for further improvement.

The trend of the infant mortality rate since the beginning of the century in the Administrative County is shown in the following table:—

Period	Average Infant Mortality Rate	Period	Average Infant Mortality Rate
1900-1909	139	1940-1944	51
1910-1919	112	1945-1949	43
1920-1929	82	1950-1954	31
1930-1939	62	1955	26

In the Administrative County there was no appreciable variation in the rate of infant mortality from the various causes in 1955 as compared with recent years. Deaths from infective and parasitic diseases, and respiratory diseases continue to decline slightly but the group comprising the hard core of infant mortality — congenital malformations, premature birth and atelectasis remains at the same level and requires further investigation.

The mortality of infants at various periods in the first year of life is shown below for the past seven years for the Administrative County:—

	Number of Deaths							Deaths per 1,000 Live Births						
	1949	1950	1951	1952	1953	1954	1955	1949	1950	1951	1952	1953	1954	1955
<i>Male Infants</i>														
Under 4 weeks ...	323	319	297	285	265	252	253	23.1	23.8	22.8	22.6	20.3	20.2	20.0
4 weeks—3 months ...	94	88	72	46	62	61	116	6.7	6.6	5.5	3.6	4.8	4.9	9.1
3—6 months ...	94	76	61	47	56	52		6.7	5.7	4.7	3.7	4.3	4.1	
6—12 months ...	73	48	53	38	43	36		5.2	3.6	4.1	3.0	3.3	2.9	
Total under 1 year	584	531	483	416	426	401	369	41.7	39.7	37.1	32.9	32.7	32.1	29.1
<i>Female Infants</i>														
Under 4 weeks ...	259	203	176	205	200	189	175	19.7	16.2	14.6	17.2	16.7	16.2	14.6
4 weeks—3 months ...	68	57	51	45	43	37	101	5.2	4.6	4.2	3.8	3.6	3.2	8.5
3—6 months ...	61	69	54	36	27	32		4.6	5.5	4.5	3.0	2.2	2.7	
6—12 months ...	65	44	34	34	37	18		4.9	3.5	2.8	2.9	3.1	1.6	
Total under 1 year	453	373	315	320	307	276	276	34.4	29.8	26.1	26.9	25.6	23.7	23.1
<i>All Infants</i>														
Under 4 weeks ...	582	522	473	490	465	441	428	21.4	20.2	18.8	20.0	18.6	18.3	17.4
4 weeks—3 months ...	162	145	123	91	105	98	217	6.0	5.6	4.9	3.7	4.2	4.0	8.8
3—6 months ...	155	145	115	83	83	84		5.7	5.6	4.6	3.4	3.3	3.5	
6—12 months ...	138	92	87	72	80	54		5.1	3.5	3.5	2.9	3.2	2.2	
Total under 1 year	1037	904	798	736	733	677	645	38.2	34.9	31.8	30.0	29.3	28.0	26.2

There was a marked reduction in neo-natal deaths in 1955. The number of infants dying in the first 4 weeks of life was 428 giving a neo-natal mortality rate of 17.4 per thousand live births, which is the lowest rate yet recorded for the Administrative County and compares favourably with the rate of 17.3 for England and Wales.

The table below gives an analysis of the mortality of infants under 4 weeks of age in the years 1949 to 1954 inclusive. The figures for 1955 are not yet available.

	Number of Deaths						Deaths per 1,000 Live Births					
	1949	1950	1951	1952	1953	1954	1949	1950	1951	1952	1953	1954
Under 1 day	237	193	176	229	198	184	8.7	7.5	7.0	9.3	7.9	7.6
1—7 days	203	218	221	183	190	193	7.5	8.4	8.8	7.5	7.6	8.0
1—4 weeks	142	111	76	78	77	64	5.2	4.3	3.0	3.2	3.1	2.7
Total under 4 weeks	582	522	473	490	465	441	21.4	20.2	18.8	20.0	18.6	18.3

The neo-natal mortality rate for the Administrative County and the country as a whole has declined in recent years but not so rapidly as the total infant mortality rate. In the short period covered by the above tables it will be seen that while total infant mortality fell by 31 per cent. neo-natal mortality only declined by 19 per cent.

Many of the deaths in the neo-natal period are of children who live no longer than a day, or at most a week, and the prevention of these deaths is to be sought in the ante-natal period, obstetric care, or in sociological and genetic factors.

The decline in infant mortality has focussed attention on the problem of mortality of infants before, during and just after birth and a term "perinatal mortality" has been introduced to define these fatalities, the generally accepted combination being of stillbirths and deaths in the first week of life.

Although in recent years great improvements in infant mortality generally have been made, the perinatal mortality rate has declined only slightly. More than half of the deaths under one year of age now take place in the first week of life and two-thirds before the 28th day. In 1948, the total infant mortality per 1,000 live births fell from 45 to 39 and has progressively decreased year by year and, as mentioned previously, in 1955 the rate of 26 is the lowest yet recorded for the Administrative County. The perinatal rate has, however, remained virtually stationary around 40 per 1,000 total births, which at the present rate, represents a loss of approximately 1,000 lives.

Although the figures for 1955 are not yet available, during the period covered by the following table it will be seen that, apart from a slight increase in 1953, the death rate of infants between one week and under one year has fallen progressively and the rate for 1954 is only 45 per cent. of what it was in 1947.

	1947	1948	1949	1950	1951	1952	1953	1954
Perinatal mortality (per 1,000 total births)	42.2	39.2	40.0	39.2	41.3	41.0	39.8	41.1
Infant deaths at one week and over (per 1,000 total births)	27.1	23.0	21.4	18.6	15.6	12.9	13.4	12.1

Much of this perinatal loss is associated with premature termination of pregnancy and nearly half of the stillbirths and about 60 per cent. of the infant deaths under one week weighed 5½lb. or less.

Deaths

During the year 18,887 deaths from all causes were assigned to the Administrative County giving a crude, or true, death rate of 11.7 compared with 11.9 in 1954 and 11.6 in 1953.

The age and sex distribution of the population varies from area to area and crude rates fail to give a true mortality index when comparing different areas. For example, of two areas or districts, the one containing the larger proportion of elderly people almost certainly will have the higher crude death rate although the environmental conditions may be better than in the other. In order to make proper comparisons of the mortality factors operating in one area with those of other areas and with the country as a whole, an adjustment to the crude rate is necessary to make allowances for the differing constitution of the population.

The adjusted rates from all causes for the past five years for the aggregates of Boroughs and Urban Districts, Rural Districts and for the Administrative County along with the rates for England and Wales are given in the following table:—

Year	Boroughs and Urban Districts	Rural Districts	Administrative County	England and Wales
1951	13.6	11.9	13.2	12.5
1952	12.3	10.8	12.0	11.3
1953	12.6	10.4	12.1	11.4
1954	12.8	11.4	12.5	11.3
1955	12.7	11.0	12.3	11.7

The following table shows, in age groups, the deaths in 1955 and in each of the previous ten years:—

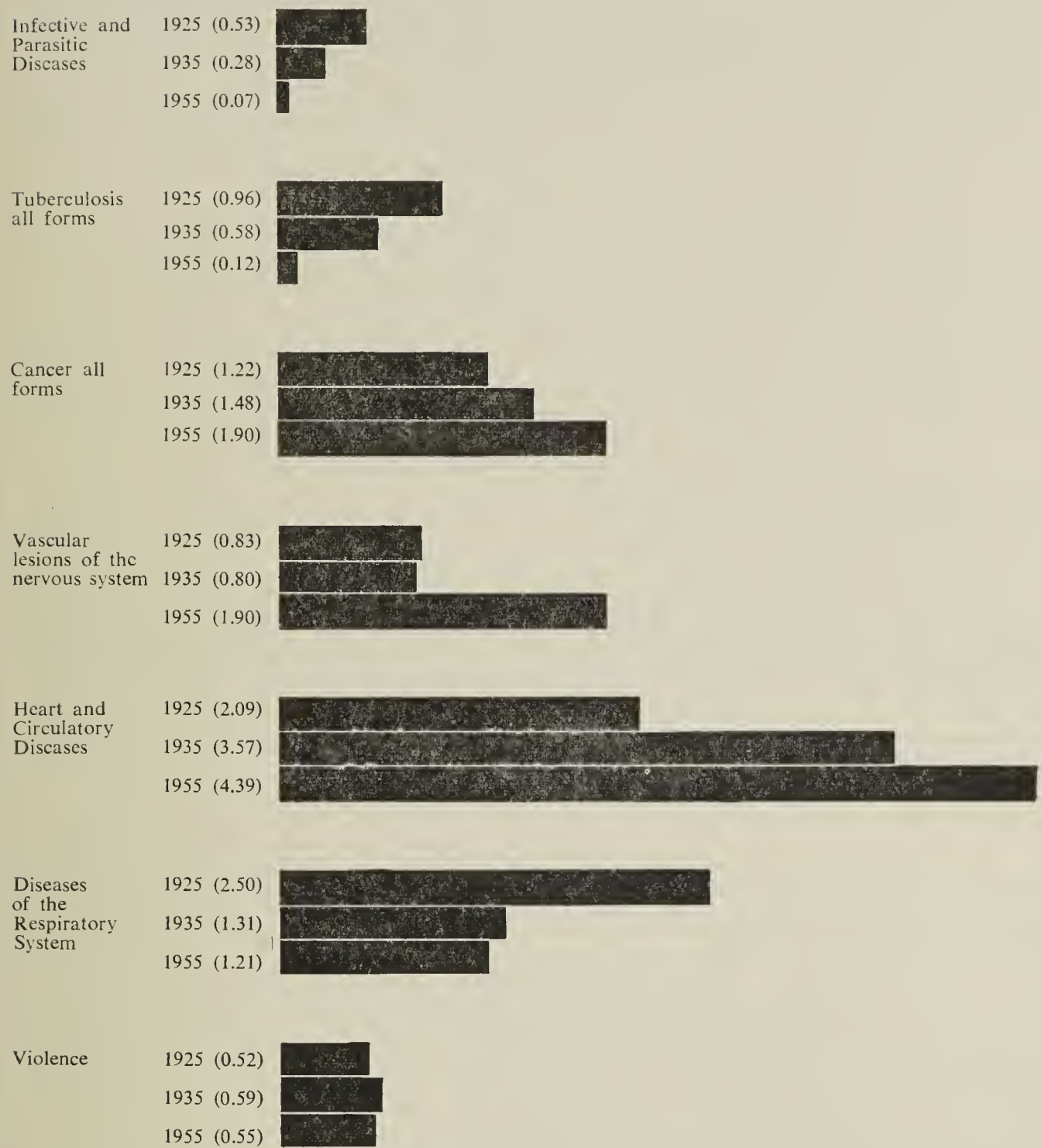
	Age at Death								Total
	Under 1 year	1 and under 5	5 and under 15	15 and under 25	25 and under 45	45 and under 65	65 and under 75	75 and over	
1945	1,313	292	209	341	1,177	4,427	4,974	5,117	17,850
1946	1,304	204	166	322	1,222	4,265	4,952	5,487	17,922
1947	1,462	242	192	305	1,238	4,331	5,236	5,713	18,719
1948	1,129	206	149	268	1,133	4,207	4,975	5,582	17,649
1949	1,037	191	166	247	1,049	4,396	5,545	6,419	19,050
Ave. 5 years 1945-49	1,249	227	176	297	1,164	4,325	5,136	5,664	18,238
Percentage of Total Deaths	6.8	1.2	1.0	1.6	6.4	23.7	28.2	31.1	100.0
1950	904	161	126	211	943	4,245	5,450	6,751	18,791
1951	798	175	135	206	964	4,521	5,853	7,553	20,205
1952	736	123	100	153	873	4,254	5,146	6,887	18,272
1953	733	120	104	185	835	4,349	5,188	6,990	18,504
1954	677	101	109	153	834	4,382	5,388	7,435	19,079
Ave. 5 years 1950-54	769	136	115	182	890	4,350	5,405	7,123	18,970
Percentage of Total Deaths	4.1	0.7	0.6	1.0	4.7	22.9	28.5	37.5	100.0
1955	645	115	115	155	807	4,347	5,381	7,322	18,887
Percentage of Total Deaths	3.4	0.6	0.6	0.8	4.3	23.0	28.5	38.8	100.0

It will be seen that the decline in the number of deaths under 45 years has continued year by year but the ageing process of the population is reflected in the mortality figures; in 1955 over two-thirds of the total deaths were of persons aged 65 years or over with consequent reduced proportions in the younger age groups. Compared with the average for the years 1945-49, the percentages of deaths under 1 year, 1 year and under 5, and 15 and under 25 years to total deaths in 1955 were just a half in each case, closely followed by the 5 and under 15 years age group which shows a 40 per cent. reduction. The increasing preponderance of elderly people in the population also governs, to some extent, the relative order of frequency of the principal causes of death, and the table below shows the number of deaths in 1955 allocated to the Administrative County classified according to age and cause:—

Cause of Death	Age at Death								Total
	Under 1 year	1 and under 5	5 and under 15	15 and under 25	25 and under 45	45 and under 65	65 and under 75	75 and over	
1. Tuberculosis, respiratory	—	—	—	4	41	81	30	13	169
2. Tuberculosis, other	2	3	3	—	2	8	4	1	23
3. Syphilitic disease	—	—	—	—	3	22	13	6	44
4. Diphtheria	—	—	—	—	—	—	—	—	—
5. Whooping cough	2	1	—	—	—	—	—	—	3
6. Meningococcal infections	2	5	—	—	1	1	1	—	10
7. Acute poliomyelitis	—	—	2	1	4	—	—	—	7
8. Measles	—	4	—	—	—	—	—	—	4
9. Other infective and parasitic diseases	3	2	1	1	8	6	11	5	37
Total—Infective and Parasitic Diseases, exc. Tub.	7	12	3	2	16	29	25	11	105
10. Malignant neoplasm, stomach	—	—	—	1	20	163	183	148	515
11. Malignant neoplasm, lung, bronchus	—	—	—	1	20	258	133	53	465
12. Malignant neoplasm, breast	—	—	—	—	31	142	81	53	307
13. Malignant neoplasm, uterus	—	—	—	—	23	69	43	18	153
14. Other malignant and lymphatic neoplasms	1	4	8	12	80	490	473	458	1,526
15. Leukaemia, aleukaemia	—	8	10	5	13	26	16	8	86
Total—All forms of Cancer	1	12	18	19	187	1,148	929	738	3,052
16. Diabetes	—	—	1	1	7	38	54	46	147
17. Vascular lesions of nervous system	—	—	1	4	28	522	1,022	1,481	3,058
18. Coronary disease, angina	—	—	—	2	52	857	1,008	802	2,721
19. Hypertension with heart disease	—	—	—	—	3	89	181	230	503
20. Other heart disease	—	—	3	7	96	344	733	1,806	2,989
21. Other circulatory disease	—	—	2	3	14	97	211	535	862
Total—Heart and Circulatory Diseases	—	—	5	12	165	1,387	2,133	3,373	7,075
22. Influenza	—	—	—	1	1	18	23	30	73
23. Pneumonia	81	11	1	3	16	92	142	256	602
24. Bronchitis	30	5	—	3	18	269	368	416	1,109
25. Other diseases of respiratory system	2	4	3	3	16	59	45	39	171
Total—Diseases of the Respiratory System incl. Influenza and excl. Tuberculosis	113	20	4	10	51	438	578	741	1,955
26. Ulcer of stomach and duodenum	—	—	—	—	11	62	59	46	178
27. Gastritis, enteritis and diarrhoea	25	6	—	3	4	19	18	25	100
28. Nephritis and nephrosis	—	1	5	3	34	65	51	54	213
29. Hyperplasia of prostate	—	—	—	—	—	3	28	78	109
30. Pregnancy, childbirth, abortion	—	—	—	3	14	—	—	—	17
31. Congenital malformations	123	20	6	3	12	5	7	2	178
32. Other defined and ill-defined diseases	356	16	29	22	110	309	290	497	1,629
33. Motor vehicle accidents	—	9	12	35	44	38	23	16	177
34. All other accidents	17	15	26	25	52	102	82	188	507
35. Suicide	—	—	1	8	27	87	48	12	183
36. Homicide and operations of war	1	1	1	1	2	6	—	—	12
Total—Accidents, Suicide and Violence	18	25	40	69	125	233	153	216	879
Total—All Causes	645	115	115	155	807	4,347	5,381	7,322	18,887

When comparisons of mortality from the principal causes in 1955 are made with those of twenty or thirty years ago the extending longevity of the population, coupled with the increased degree of control over certain communicable diseases is apparent. The latter enables prevention and cure of some of the commoner infectious diseases to be made while the former takes more and more persons into the age groups where heart and circulatory failure and cancer are commoner than at earlier ages. The changing pattern is illustrated in the diagram below which gives the principal causes of death per 1,000 population in each of the years 1925, 1935 and 1955:—

WEST RIDING ADMINSTRATIVE COUNTY
PRINCIPAL CAUSES OF DEATH PER 1,000 POPULATION



Diseases of the Respiratory System includes Influenza and excludes Pulmonary Tuberculosis.

With more than two-thirds of the deaths occurring in persons aged 65 years and over it is not surprising that the diseases given in the table below accounted for 14,896 deaths in 1955 which is 78.9 per cent. of the total deaths. It will be seen that heart disease in all its forms was the major cause accounting for 37 per cent. of all deaths followed by cancer and vascular lesions of the nervous system each with 16 per cent. and the combination of bronchitis and pneumonia 9 per cent.

	Death rates per 1,000 population					
	1950	1951	1952	1953	1954	1955
Heart and circulatory diseases ...	4.39	4.72	4.35	4.26	4.54	4.39
Cancer	1.83	1.80	1.92	1.88	2.01	1.90
Vascular lesions of nervous system	1.59	1.72	1.74	1.76	1.84	1.90
Bronchitis and pneumonia ...	1.07	1.35	1.01	1.10	1.06	1.06
(a) Totals of the above	8.88	9.59	9.02	9.00	9.45	9.25
(b) Death rate — all causes ...	11.80	12.74	11.49	11.62	11.92	11.73
Percentage col. (a) to col. (b) ...	75.3	75.3	78.5	77.5	79.3	78.9

During the year heart and circulatory diseases caused 7,075 deaths, 194 fewer than in 1954, yet amounting to 37 per cent. of all deaths. The majority of deaths were, of course, of elderly people and only 182 deaths allocated to this group were of persons under 45 years of age. The mortality from certain individual causes declined slightly yet improvements, when indicated only by decimal points, should not be taken as suggesting a downward trend but should be accepted with reserve especially when considering this group of diseases.

The number of deaths and the mortality rates per 1,000 of the population in each of the years 1950-55 are as follows:—

Year	Coronary disease, angina		Hypertension with heart disease		Other heart disease		Other circulatory disease		Total	
	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate	No. of Deaths	Death Rate
1950	2,037	1.28	495	0.31	3,751	2.36	698	0.44	6,981	4.39
1951	2,234	1.41	511	0.32	4,017	2.53	733	0.46	7,495	4.72
1952	2,370	1.49	376	0.24	3,482	2.19	691	0.43	6,919	4.35
1953	2,364	1.49	404	0.25	3,330	2.09	684	0.43	6,782	4.26
1954	2,736	1.71	472	0.30	3,222	2.01	839	0.52	7,269	4.54
1955	2,721	1.69	503	0.31	2,989	1.86	862	0.54	7,075	4.39

There were 3,052 deaths from all forms of cancer in 1955, compared with 3,210 in 1954. These deaths formed 16 per cent. of total deaths and, while there was a welcome reduction in deaths from this disease as compared with the previous year, it must be remembered that greater numbers of people are entering the age groups most subject to its attack and it seems more than likely that in future years the number of deaths will tend progressively to increase.

The number of deaths from cancer, according to sex and site, for the past six years is given in the following table:—

	Number of Deaths																	
	1950			1951			1952			1953			1954			1955		
	M.	F.	P.	M.	F.	P.	M.	F.	P.	M.	F.	P.	M.	F.	P.	M.	F.	P.
Stomach	294	290	584	302	228	530	358	218	576	298	242	540	349	264	613	301	214	515
Lung, Bronchus	280	57	337	302	58	360	335	60	395	381	63	444	404	61	465	393	72	465
Breast	1	250	251	—	253	253	—	284	284	5	283	288	1	285	286	2	305	307
Uterus	—	142	142	—	166	166	—	157	157	—	156	156	—	172	172	—	153	153
Other Malignant and Lymphatic Neoplasms	820	725	1,545	855	636	1,491	899	681	1,580	811	680	1,491	886	719	1,605	842	684	1,526
Leukaemia, Aleukaemia	30	19	49	26	31	57	30	32	62	33	38	71	29	40	69	46	40	86
Total, All Sites	1,425	1,483	2,908	1,485	1,372	2,857	1,622	1,432	3,054	1,528	1,462	2,990	1,669	1,541	3,210	1,584	1,468	3,052

Apart from small fluctuations from year to year, there has been little change in the number of deaths from cancer of the stomach and it still retains its position as the leading site of malignant growth but by a diminishing margin over lung and bronchus.

In recent years deaths from lung cancer have progressively increased and in 1955 over 15 per cent. of all cancer deaths were of this site. The increase is more pronounced in males and, although much has been said already about the relationship between lung cancer and heavy smoking, especially cigarettes, and the possible deleterious effect of atmospheric pollution, research is still proceeding and it is in our own interests that potential causatives should be recognised and eliminated where possible. With this in mind I welcome the Government's Clean Air Bill and hope that the operative date is not long delayed.

The gradual increase in the number of deaths from leukaemia and aleukaemia continued; there were 86 deaths from this cause in 1955 as compared with 49 in 1950, a 75 per cent. increase.

Deaths classified to vascular lesions of the central nervous system (cerebral haemorrhage etc.) continue to increase. In 1955 there were 3,058 deaths from this cause with a resultant rate per thousand of the population of 1.90 compared with 2,946 deaths (1.84) in 1954 and 2,806 (1.76) in 1953.

This condition, like heart disease and cancer, is one which principally affects older people and of the 3,058 deaths in 1955 a third were between the ages of 65 and 74 and nearly a half were aged 75 years or over.

The similarity in the climatic conditions in 1954 and 1955 is reflected in the deaths attributable to bronchitis and pneumonia; in 1955 these diseases caused 1,711 deaths as compared with 1,697 in the previous year and although there was an increase from 566 to 602 deaths from pneumonia there was a compensatory reduction in mortality from bronchitis, from 1,131 to 1,109.

The absence of an influenza epidemic also contributed to the respiratory deaths remaining at the same level. There have been recent signs of a biennial epidemicity of influenza, 1949, 1951 and 1953 were years of higher mortality but 1955 proved to be the exception with 73 deaths, 23 fewer than in the previous year.

There has been much speculation as to the nature and extent of the effects of atmospheric pollution on health.

It has been estimated that in Great Britain each year nearly 8 million tons of atmospheric pollution are produced from the combustion of coal and its derived fuels, e.g. smoke, gases, grit and dust from domestic and industrial chimneys, locomotives and ships, exhaust gases from motor vehicles, and the solid and gaseous pollutants from chemical works and industrial processes. Almost all the 92 natural elements in one combination or another can be found in atmospheric pollution and the overall extent to which atmospheric pollution adversely affects health cannot be accurately assessed; there are many factors involved and it is not possible to distinguish clearly between the effects on health of different forms of pollution. Much research is still required for as yet no conclusive opinion has been expressed as to the effect of individual atmospheric pollutants on persons in relatively good health nor the effect of the simultaneous action of a number of substances.

There is, however, no doubt that atmospheric pollution is injurious to both physical and mental health and this has been shown in the past by the disasters in the Meuse Valley (Belgium) in 1930 when more than 60 people died as a direct cause of fog which lasted for 6 days, and at Donora, Pennsylvania in the United States in 1948 when fog lasted for 3 days and during a two-week period 18 deaths were attributed to the fog. More recently, the effects of the London fog of December, 1952 resulted in the deaths of some 4,000 people.

For England and Wales as a whole, statistics have shown that there is a clear association between atmospheric pollution and the incidence of bronchitis and other respiratory diseases; every year the death rate in England and Wales is much higher than in other European countries for which reliable figures are available. Not all the excess can necessarily be attributed to air pollution since other factors, e.g. age of the population, climatic and housing conditions, are involved but, in general, the higher death rates are to be found in the industrial towns which are liable to heavy pollution.

So far as the West Riding Administrative County is concerned, no figures are available of the number of people who are ill from the effects of atmospheric pollution and it is not possible to say that any particular death was due solely to this source.

In the table given below the column "Atmospheric pollution average for 5 years 1951-55" gives the average of the pollution deposited in tons per square mile as recorded by the various deposit gauges situate in the County while the column headed "Sulphur Measurements" shows the amounts of sulphur pollution as measured by lead peroxide instruments sited alongside the deposit gauges.

It will be seen from the Table that the District with the highest amount of Total Solids deposited is Rawmarsh U.D. which also has the highest sulphur pollution. Much of the solids recorded by the deposit gauge at Granby House, Rawmarsh, is industrial pollution caused by two blast furnaces used for iron smelting and reference to the abnormal atmospheric pollution conditions existing in the vicinity of this deposit gauge is made on page 91. The death rates for this District in the period covered by the Table are, however, below the average for the remaining Districts given. If, because of its abnormal pollution, Rawmarsh U.D. is discounted, the District with the next highest total solids recorded is Doncaster R.D. and the next highest sulphur pollution was at Castleford M.B. For both these Districts the death rates are low in comparison with those obtaining in other Districts. At the other end of the scale, the District with the least recorded pollution for total solids and third least sulphur pollution is Harrogate M.B. but the death rates from the various causes are consistently high.

It must, of course, be borne in mind that the atmospheric pollution instruments can only record pollution over a circumscribed area and, as mentioned previously, the age constitution of the population at risk is a factor involved. A District which has a large proportion of elderly people usually has a high general death rate and, as the elderly are more susceptible to respiratory diseases, a high proportion of the deaths are from these causes. Again, if a locality is renowned for its healthy environment, it follows that more and more people, if they are in a position to do so, will wish to reside there and gain relief from their various ailments yet, due to the way in which deaths are allocated, the deaths of immigrants into the District are not transferred back to the District in which they contracted the infection but remain debited to the District of their adoption, thus, in effect, giving a false picture of this District's environment.

Similarly, the Districts which have Homes or Hospitals for Old Persons situate within their boundaries have false death rates and, while a compensating factor can be applied to deaths from all causes, no accurate correcting factor can be applied to deaths from individual causes to make appropriate allowances. For example, Hemsworth U.D. has less than average pollution but its death rates from the diseases shown are relatively high.

From a study of the statistics given in the Table it is apparent that, so far as the Administrative County is concerned, no reliable conclusions may be drawn and, whilst it is reasonable to suppose that there is a sound relationship between atmospheric pollution and deaths from various causes, insufficient information is available as yet for proof to be established.

County District	Density (Persons per Acre)	Atmospheric Pollution Average for 5 years 1951-55			Death Rates — Average for 5 years 1951-55							
		Site	Total Solids Deposited (tons per sq. mile)	Sulphur Measurements (Mgms. SO ₃ per 100 sq. fms. per day)	Cancer of Lung	Cancer All Forms	Bronchitis	Pneumonia	Other Respiratory Diseases	Influenza	Total Diseases of Respiratory System (Cols. 8-11 inc.)	Tuberculosis Respiratory
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
Urban Districts and Municipal Boroughs:—												
Aireborough	4.0		14.39	1.55	0.29	1.92	0.53	0.46	0.14	0.25	1.39	0.19
Batley	9.0		18.79	1.68	0.26	2.05	1.06	0.36	0.20	0.12	1.74	0.12
Bentley with Arksey	4.1		13.85	1.09	0.21	1.81	0.98	0.31	0.16	0.05	1.50	0.31
Bingley	1.9	a	10.06	1.12								
		b	11.22	0.70								
		Average	10.64	0.91	0.28	2.08	0.79	0.26	0.10	0.19	1.34	0.17
Castleford	9.7	c	17.21	2.24								
		d	19.35	2.91								
		e	17.98	1.84								
		f	11.91	1.97								
		Average	16.61	2.24	0.28	1.64	0.79	0.39	0.10	0.07	1.35	0.23
Colne Valley	1.4	g	15.01	1.70								
		h	16.60	1.38								
		Average	15.81	1.54	0.21	2.20	0.65	0.26	0.09	0.07	1.08	0.08
Darton	3.0		13.97	0.98	0.24	1.44	0.67	0.27	0.04	0.11	1.09	0.17
Elland	3.2		13.48	1.73	0.27	2.27	0.62	0.45	0.18	0.18	1.43	0.12
Goole	15.2		10.77	1.05	0.36	2.30	1.50	0.49	0.08	0.18	2.25	0.20
Harrogate	6.2		8.57	0.78	0.49	2.49	0.51	0.45	0.10	0.15	1.21	0.17
Hebden Royd	1.4		16.60	1.35	0.28	2.55	1.04	0.36	0.06	0.24	1.69	0.12
Hemsworth	3.3		12.00	1.29	0.38	3.28	1.26	0.63	0.29	0.09	2.27	0.28
Holmfirth	1.1		12.24	0.95	0.24	2.44	1.22	0.27	0.10	0.21	1.80	0.12
Horsbury	6.3		15.44	1.46	0.22	1.99	0.77	0.32	0.15	0.15	1.39	0.10
Horsforth	5.2		14.54	1.37	0.33	1.87	0.77	0.56	0.11	0.10	1.55	0.14
Keighley	2.4	i	13.65	1.46								
		j	8.95	1.33								
		k	16.83	1.55								
		l	19.87	1.92								
		Average	14.82	1.57	0.29	2.34	0.88	0.33	0.07	0.11	1.39	0.16
Morley	4.2		18.96	1.88	0.31	2.05	0.89	0.40	0.13	0.13	1.56	0.11
Otley	3.9		12.66	0.82	0.30	1.72	0.61	0.44	0.07	0.09	1.21	0.25
Rawmarsh	7.3	m	19.53	1.84								
		n	91.83	3.35								
		Average	55.68	2.60	0.27	1.64	0.92	0.31	0.08	0.11	1.41	0.09
Ripon	5.5		9.14	1.07	0.38	2.09	0.59	0.73	0.08	0.10	1.50	0.18
Rothwell	2.3		13.05	1.72	0.28	1.86	0.87	0.82	0.18	0.11	1.99	0.15
Saddleworth	0.9		15.79	1.51	0.30	2.00	0.78	0.28	0.08	0.11	1.25	0.11
Shipley	14.9		14.09	1.22	0.31	2.07	0.77	0.57	0.09	0.19	1.61	0.14
Skipton	3.1		16.67	0.64	0.38	2.77	0.64	0.50	0.14	0.09	1.38	0.11
Spensborough	4.5		14.63	1.86	0.34	2.27	0.91	0.33	0.13	0.09	1.45	0.15
Wombwell	4.9		15.85	1.22	0.14	1.79	0.72	0.32	0.14	0.05	1.23	0.21
Rural Districts:—												
Doncaster	0.7		40.12	1.41	0.24	1.54	0.68	0.26	0.12	0.11	1.17	0.21
Thorne	0.9		11.50	0.93	0.18	1.36	0.98	0.34	0.11	0.13	1.56	0.22
Wetherby	0.3		9.81	0.72	0.20	1.70	0.40	0.39	0.05	0.14	0.99	0.10
Wortley	0.9		9.54	0.88	0.20	1.56	0.51	0.43	0.08	0.10	1.12	0.16

a. Bingley — St. Ives
b. Bingley — Town Hall
c. Castleford — Carlton Street
d. Castleford — Cinder Lane
e. Castleford — Ings Lane

f. Castleford — Redhill Road
g. Colne Valley — Slaithwaite
h. Colne Valley — Marsden Park
i. Keighley — Abattoir
j. Keighley — Oldfield

k. Keighley — Low Bridge
l. Keighley — Library
m. Rawmarsh — Barbers Avenue
n. Rawmarsh — Granby House

A description of the sites of the above atmospheric pollution instruments appears on page 88.

Deaths from the individual causes which can be classified under the general heading of "Violence" all increased slightly over the previous year; motor vehicle accidents from 167 to 177; all other accidents from 474 to 507; suicide from 157 to 183 and homicide and operations of war from 11 to 12. Although the number of deaths from this group classification fluctuates from year to year the tendency is towards an upward trend.

In 1955, of the 507 deaths from accidents other than those caused by motor vehicles, 240 were as a result of an accident in the home or residential institution. These fatalities from home accidents increased slightly as compared with the previous year (238) and they are well in excess of the number of deaths attributed to many causes for which a separate classification is provided.

Roughly four-fifths of these fatal accidents occur at the two extremes of life, i.e. in children under 5 years of age and in elderly people of 65 years and over. The proportion of deaths in various age groups in 1954 and 1955 was as follows:—

Years							
	Under 1	1-4	5-14	15-44	45-64	65-74	75 and over
1954	5.0	2.1	1.7	4.2	8.8	21.0	57.2
1955	3.8	3.3	2.1	4.6	13.7	19.2	53.3

The types of fatal home accidents do not differ greatly from year to year; the commoner causes in 1955 with percentages to total home accidents were falls 69; burns and scalds 12; coal gas poisoning 9; suffocation 7; and other poisonings 3. Nearly nine-tenths of the falls, about half the burns and scalds and two-thirds of the deaths from coal gas poisoning happen to old people over 65; while half the suffocations and a quarter of the burns and scalds are of children under 5 years of age.

The number of deaths from accidental poisoning varies from year to year but far too many tragedies are caused by parents and other responsible persons not taking sufficient care to protect their children against such unnecessary accidents.

The prevention of home accidents is receiving increasing attention from all workers in the field of public health and our propaganda efforts are being intensified in the hope that much pain and suffering as well as a large number of deaths brought about by home accidents might be avoided.

There was an immense reduction in mortality from tuberculosis in 1955 as compared with previous years; respiratory deaths declined from 310 for the average for the five years 1950-54 and 261 in the year 1954 to only 169, and other forms from 48 for the average of the years 1950-54 to 26 in 1954 and 23 in 1955. The resultant death rates per 1,000 of the population were respiratory 0.11 and other forms 0.01 and once again it is gratifying, although somewhat monotonous, being able to state that these are the lowest rates ever recorded. The rates continue to be less than the corresponding rates for England and Wales of 0.13 and 0.02 respectively and there appears hopeful signs that we are well on the way towards the conquest of this disease.

For the first year ever there was no notification of diphtheria in the Administrative County and, following the black year of 1954 in which there were 2 deaths, it is highly satisfactory that we should revert to the ideal attainment achieved in the years 1951-53 inclusive of no deaths from this disease.

Child Mortality

Deaths of children between the ages of 1 and 5 years numbered 115. Although this total is an increase of 14 over the previous year it is the second lowest ever recorded for the Administrative County and compares favourably with the average mortality of 136 in the years 1950-54 inclusive.

Great improvements in childhood mortality have been made since the beginning of the century with the result that the total deaths in 1955 are only 5 per cent. of the average for the five years 1911-15. Loss of child life from infective and parasitic diseases, tuberculosis, respiratory diseases, diarrhoea and many of the lesser known diseases all have decreased enormously but there are still a number of deaths which might be prevented. As mentioned previously accidents in the home take an unnecessary toll of life and in 1955, of the deaths of children in this age group, fatal home accidents were the fourth largest cause of death; of the 24 deaths allocated to all types of accidents in 1955, 8, or 1 out of every 15 childhood deaths, were classified to this cause which to a great extent is avoidable.

The general pattern of the causes of death has varied considerably in the period covered by the following table. The majority of causes show a definite downward trend but deaths from all forms of cancer continue to rise slightly.

The table below gives, for certain periods, the number of deaths of children aged 1-5 years from the various causes and the death rates per 1,000 children living in the age group in the Administrative County:—

Cause of Death	Annual Averages for Quinquennia					1950	1951	1952	1953	1954	1955
	1911-15	1927-31	1935-39	1940-44	1945-49						
Measles	439	107	27	18	10	3	8	2	4	1	4
Whooping cough	167	67	29	20	11	3	10	5	6	1	1
Diphtheria	110	47	51	32	5	1	—	—	—	1	—
Other infective and parasitic diseases, excl. tuberculosis	54	45	18	13	7	13	12	2	10	8	7
Tuberculosis, respiratory	47	13	5	4	4	1	3	—	—	1	—
Tuberculosis, other	201	82	37	39	30	15	16	13	10	1	3
Cancer	3	5	4	6	4	8	12	8	8	10	12
Heart and circulatory diseases	4	3	2	1	1	—	—	1	1	—	—
Influenza	6	43	10	11	4	2	2	2	3	2	—
Pneumonia	457	321	121	85	42	24	22	27	8	15	11
Bronchitis	150	42	10	17	9	2	8	4	8	6	5
Other diseases of respiratory system	49	15	6	5	3	6	1	2	—	2	4
Diarrhoea and other digestive diseases	248	45	38	23	17	3	3	2	5	8	6
Congenital debility, malformations, premature births, etc.	12	9	7	10	12	9	21	10	10	13	20
Accidents	82	54	50	47	38	39	29	28	23	17	24
Other causes	323	119	52	45	30	32	28	17	24	15	18
All causes	2,352	1,017	467	376	227	161	175	123	120	101	115
Death rate per 1,000 living in the age group	17.13	10.62	5.09	4.17	2.23	1.41	1.53	1.15	1.17	1.01	1.17

Maternal Mortality

There were 17 maternal deaths (including deaths due to abortion) giving a rate per 1,000 live and still births of 0.67 which compares favourably with 22 deaths and a rate of 0.89 in 1954. Included in the total was a death where the interval between the maternal condition and death was stated by the Registrar-General to exceed 12 months; actually the interval was 5 years, but in accordance with international agreement in spite of the lapse of time the death has to be so classified. Even with this death included the rate is the second lowest ever recorded for the Administrative County and is in keeping with the corresponding rate for England and Wales of 0.64.

The table below shows the number of deaths and the mortality rate for the past 27 years for the Administrative County:—

Year	No. of deaths from			Mortality Rate per 1,000 live and stillbirths		
	Puerperal and post abortive sepsis	Other maternal causes	Total	Puerperal and post abortive sepsis	Other maternal causes	Total
1929	58	76	134	2.16	2.83	4.99
1930	63	99	162	2.32	3.64	5.96
1931	57	88	145	2.19	3.37	5.56
1932	50	77	127	1.96	3.01	4.97
1933	48	96	144	1.98	3.96	5.94
1934	54	82	136	2.20	3.33	5.53
1935	43	62	105	1.78	2.56	4.34
1936	39	61	100	1.62	2.54	4.16
1937	21	69	90	0.87	2.87	3.74
1938	25	62	87	1.03	2.55	3.58
1939	19	51	70	0.79	2.13	2.92
1940	22	53	75	0.92	2.21	3.13
1941	17	48	65	0.68	1.93	2.61
1942	25	59	84	0.96	2.27	3.23
1943	18	46	64	0.68	1.72	2.40
1944	18	40	58	0.60	1.32	1.92
1945	14	32	46	0.53	1.20	1.73
1946	14	41	55	0.46	1.34	1.80
1947	7	36	43	0.21	1.07	1.28
1948	3	31	34	0.10	1.05	1.15
1949	4	19	23	0.15	0.68	0.83
1950	*	*	26	*	*	0.98
1951	*	*	24	*	*	0.93
1952	*	*	20	*	*	0.80
1953	*	*	13	*	*	0.51
1954	*	*	22	*	*	0.89
1955	*	*	17	*	*	0.67

*Deaths from puerperal and post abortive sepsis are no longer given separately.

A revised international classification of deaths was introduced in 1950 and the table below gives the maternal death rates per thousand live and still births for the Administrative County and England and Wales based on this revised classification in respect of the years 1951 to 1954 inclusive. The rates for 1955 are not yet available.

Cause of Death	1951		1952		1953		1954	
	W.R. Admin. County	England & Wales	W.R. Admin. County	England & Wales	W.R. Admin. County	England & Wales	W.R. Admin. County	England & Wales
Maternal Sepsis (not associated with abortion)	0.12	0.10	—	0.09	0.08	0.10	0.04	0.09
Toxaemias of pregnancy and puerperium (not associated with abortion)	0.12	0.24	0.32	0.21	0.16	0.24	0.16	0.19
Abortion with or without mention of sepsis or toxaemia	0.23	0.16	0.12	0.13	0.04	0.11	0.36	0.11
Other complications of pregnancy, childbirth and the puerperium	0.46	0.32	0.36	0.29	0.23	0.30	0.32	0.30
Total Maternal Mortality	0.93	0.82	0.80	0.72	0.51	0.75	0.89	0.70

It should be borne in mind that the rates for the Administrative County are based on a small number of deaths from individual maternal causes but with this reservation it would appear that while there have been large reductions in deaths due to maternal sepsis there has been no corresponding fall in the death rate from toxaemia.

Of the 89 County Districts in the Administrative County 74 had no maternal death and the following table, whilst being based on a small number of deaths, gives some indication as to the areas which have contributed to the fall in the County's maternal mortality rate from 1.22 for the average of the five years 1946-50 to 0.76 for the average of the five years 1951-55.

Division	5 years 1946-1950			5 years 1951-1955			Percentage decrease in rate for 1951-55 on that for 1946-50
	Total Live and Stillbirths	Maternal Deaths	Maternal Mortality Rate per 1,000 Live and Stillbirths	Total Live and Stillbirths	Maternal Deaths	Maternal Mortality Rate per 1,000 Live and Stillbirths	
1	4,861	11	2.26	4,120	5	1.21	46.46
2	1,949	4	2.05	1,547	1	0.65	68.29
3	5,016	10	1.99	4,051	4	0.99	50.25
4	5,916	8	1.35	4,850	2	0.41	69.63
5	5,905	6	1.02	5,050	1	0.20	80.39
6	2,776	—	—	2,373	—	—	—
7	1,847	5	2.71	1,788	—	—	100.00
8	5,712	2	0.35	4,841	1	0.21	40.00
9	3,894	4	1.03	3,425	6	1.75	*69.90
10	4,354	3	0.69	3,690	3	0.81	*17.39
11	6,129	8	1.31	4,953	3	0.61	53.44
12	5,643	5	0.89	5,078	2	0.39	56.18
13†	7,791	7	0.90	6,469	6	0.93	*3.33
15	4,722	6	1.27	3,883	3	0.77	39.37
16	4,952	7	1.41	3,797	1	0.26	81.56
17	4,287	2	0.47	3,503	3	0.86	*82.98
18	5,097	4	0.78	4,172	3	0.72	7.69
19	4,940	5	1.01	3,958	1	0.25	72.25
20	7,377	7	0.95	5,771	10	1.73	*82.11
22	7,086	7	0.99	6,394	5	0.78	21.21
23	6,821	10	1.47	6,422	5	0.78	46.94
25	7,666	8	1.04	6,488	5	0.77	25.96
26	4,464	5	1.12	3,999	2	0.50	55.36
27	4,243	8	1.89	3,691	2	0.54	71.43
28	5,927	12	2.02	5,307	5	0.94	53.47
29	3,824	7	1.83	3,599	4	1.11	39.34
30	6,617	9	1.36	5,603	2	0.36	73.53
31	8,334	11	1.32	7,815	11	1.41	*6.82
Total Admin. County	148,150	181	1.22	126,637	96	0.76	37.70

Percentage Increase.

† Division No. 14 was abolished as from 1st July, 1955, and the County District comprising it was included in Division No. 13 as from that date. The statistics shown above for Division No. 13 are for the Division as so enlarged.

PART II

EPIDEMIOLOGY

Incidence and Notification of Infectious Disease

Smallpox, cholera, diphtheria, membranous croup, erysipelas, scarlet fever, and the fevers known by any of the following names, typhus, typhoid, enteric, or relapsing, are compulsorily notifiable under Section 144 of the Public Health Act, 1936; chickenpox is notifiable under Section 147 of the same Act in some West Riding County Districts; food poisoning under Section 17 of the Food and Drugs Act, 1938. The following communicable diseases are compulsorily notifiable under the regulations stated in brackets—measles and whooping cough (Measles and Whooping Cough Regulations, 1940); meningococcal infection, acute poliomyelitis—paralytic and non-paralytic, and acute encephalitis—infective and post infectious (Acute Poliomyelitis, Acute Encephalitis and Meningococcal Infection Regulations, 1949); ophthalmia neonatorum (Ophthalmia Neonatorum Regulations, 1926, 1928 and 1937); puerperal pyrexia (Puerperal Pyrexia (Amendment) Regulations, 1954); tuberculosis (Tuberculosis Regulations, 1952); malaria, dysentery and acute primary and influenza pneumonia (Infectious Diseases Regulations, 1953); plague (Notification of Case of Plague (General) Regulations, 1900). The contagious diseases of syphilis, gonorrhoea and soft chancre (classified under the term venereal diseases) and scabies are not compulsorily notifiable.

With the exception of food poisoning, which is dealt with on page 33 the following table shows the number of cases in 1955 of each "notifiable" disease, being the numbers of cases originally notified and the final numbers after corrections subsequently made by the notifying medical practitioner or by the Infectious Diseases Consultant, because of revised diagnosis as a result of bacteriological reports or further observation of cases since notification:—

AGE GROUP	Scarlet Fever		Whooping Cough		Acute Poliomyelitis (Paralytic)		Acute Poliomyelitis (Non-paralytic)		Measles		Diphtheria	
	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified (All Ages)	817	833	1,487	1,609	143	118	60	43	15,140	14,301	3	4
	1,650		3,096		261		103		29,441		7	
Final numbers after correction												
Under 1 year ...	2	3	110	126	4	4	4	—	465	479	—	—
1—2 years ...	80	66	311	313	26	15	5	—	3,137	2,963	—	—
3—4 " ...	184	176	381	444	20	25	10	4	4,529	4,200	—	—
5—9 " ...	440	464	646	663	40	33	18	11	6,640	6,277	—	—
10—14 " ...	81	86	26	36	6	7	7	4	210	197	—	—
15—24 " ...	11	16	4	3	13	13	3	6	28	44	—	—
25 and over ...	7	12	10	23	21	17	8	6	39	44	—	—
Age unknown...	2	3	7	9	—	—	—	—	46	59	—	—
Totals (all ages)	807	826	1,495	1,617	130	114	55	31	15,094	14,263	—	—
	1,633		3,112		244		86		29,357		—	
AGE GROUP	Acute Pneumonia		Acute Encephalitis		Dysentery		Typhoid and Paratyphoid Fever		Erysipelas		Meningococcal Infection	
	M	F	M	F	M	F	M	F	M	F	M	F
Numbers originally notified (All Ages)	625	494	8	2	767	672	15	19	128	135	17	23
	1,119		10		1,439		34		263		40	
Final numbers after correction												
Under 5 years...	94	86	2	—	244	181	2	—	1	—	11	9
5—14 years ...	71	68	2	1	253	212	4	6	9	4	4	7
15—44 " ...	142	121	—	—	134	149	1	7	36	27	1	4
45—64 " ...	179	112	—	1	45	38	4	2	47	76	—	3
65 and over ...	133	103	—	—	14	24	2	1	33	28	—	—
Age unknown...	6	6	—	—	6	10	—	1	2	—	—	—
Totals (all ages)	625	496	4	2	696	614	13	17	128	135	16	23
	1,121		6		1,310		30		263		39	

	Numbers Originally Notified		Numbers After Correction	
Smallpox
Puerperal Pyrexia	136	136
Ophthalmia Neonatorum	15	15
Chicken Pox	370†	not corrected
Malaria	3	2

† Chicken Pox is compulsorily notifiable only in certain County Districts.

The table below affords a comparison with the preceding eight years:—

				Number of corrected notifications (Chicken Pox not corrected)								
Disease				1947	1948	1949	1950	1951	1952	1953	1954	1955
Scarlet Fever	...	...	...	2,764	3,863	3,191	2,506	1,792	2,176	2,991	1,993	1,633
Whooping Cough	...	...	...	3,424	6,201	3,947	7,669	6,933	5,865	5,821	3,252	3,112
Diphtheria	...	...	...	221	153	66	32	10	4	1	4	—
Measles	...	...	...	21,739	16,545	16,489	15,763	25,194	13,938	19,853	5,558	29,357
Acute Pneumonia												
(primary or influenzal)	...			1,188	1,308	1,456	1,207	1,739	1,366	1,585	1,144	1,121
*Meningococcal Infection	...			78	56	60	55	57	50	37	41	39
Acute Poliomyelitis (Paralytic)		}	400				150	90	103	101	44	244
Acute Poliomyelitis (non-paralytic)						41	58	28	25	20	86	
*Acute Encephalitis (infective)	...			2	1	2	6	5	6	7	4	2
*Acute Encephalitis (post infectious)				—	—	—	3	14	1	3	4	4
Dysentery	...	...	...	108	208	73	1,117	837	370	455	1,454	1,310
Ophthalmia Neonatorum	...	...	...	82	51	37	39	29	23	20	17	15
Puerperal Pyrexia	...	...	...	85	98	98	125	128	151	141	131	136
Smallpox	...	...	...	—	—	—	—	—	—	14	—	—
Enteric or Typhoid Fever												
(excluding Paratyphoid)	...			9	18	3	9	—	2	2	5	5
Paratyphoid Fever	...	...	...	16	10	11	4	62	4	10	30	25
Erysipelas	...	...	...	347	409	429	405	312	273	302	307	263
†Chicken Pox	...	...	...	550	432	827	465	797	1,350	739	694	370
§Malaria	...	...	...	11	6	2	1	2	5	14	9	2
‡Food Poisoning	...	...	...	‡	‡	329	346	138	192	329	276	346
Tuberculosis :—												
Respiratory	...	...	...	1,233	1,246	1,478	1,297	1,296	1,337	1,223	1,084	1,033
Other Forms	...	...	...	389	407	431	348	285	296	247	206	205
Total (Tuberculosis)	...			1,622	1,653	1,909	1,645	1,581	1,633	1,470	1,290	1,238

* These terms replace others in use before 1st January, 1950, for certain groups of diseases and are consistent with the international standard classification of diseases which was brought into general use on 1st January, 1950. More or less, the term “meningococcal infection” covers the same disease as the former term “cerebro-spinal fever”, but also covers a somewhat wider group of diseases; “acute encephalitis (infective)” replaces the former term “encephalitis lethargica”; “acute encephalitis (post infectious)” covers the forms of encephalitis occasionally following or associated with certain well defined infections, e.g., chickenpox, measles, mumps and vaccinia and is to bring about the notification of cases showing late effects of acute encephalitis (infective). The figures in italics in the above table show the number of cases notified under the former terms.

† Chickenpox is compulsorily notifiable only in certain County Districts, and the figures given do not, therefore, represent the full number of cases occurring in the Administrative County.

§ All the cases of malaria shown in the above table were believed to be contracted abroad except for one in 1947.

‡ Notification of cases of food poisoning, or suspected food poisoning, only became generally in operation as from 1st January, 1949.

Scarlet Fever

The number of corrected notifications of scarlet fever was 1,633, 360 less than in 1954 and is the lowest recorded total since 1918 when there were 1,314 cases. The disease continues to be relatively mild and responds readily to treatment. A feature of recent years has been the high proportion of cases of children under 10 years of age, indeed, in 1955 only 13 per cent. of the cases were 10 years of age or over.

The incidence, or attack rate, that is the number of cases per 1,000 of the population for the Administrative County was 1·01 compared with 0·73 for England and Wales. The County Districts with the highest incidence were the Urban Districts of Maltby 6·09; Mexborough 4·03; Rothwell 3·95; Swinton 3·44; Dearne 3·16; Earby 2·69; Stocksbridge 2·62; Elland 2·43; Knottingley 2·07.

Whooping Cough

Whooping cough was again less prevalent than in the previous year, only 3,112 cases being notified. Compared with 1954 this is a decrease of 140 cases and is 1,660 less than the annual average for the fifteen years in which the disease has been compulsorily notifiable. Mortality from whooping cough has also declined considerably in recent years; in 1955 there were 3 deaths as compared with the annual average over the past ten years of 23. Even so, whooping cough is still a dangerous disease and the deaths represent only a part of the morbidity and ill-health caused by an attack.

The incidence per 1,000 of the population was 1·93 (2·03 in 1954) compared with 1·78 (2·39 in 1954) for England and Wales. The Districts which experienced the highest rates were:—Knaresborough U.D. 12·48; Royston U.D. 10·48; Cudworth U.D. 8·10; Osgoldcross R.D. 6·55; Bowland R.D. 5·30; Barnoldswick U.D. 5·25; Harrogate M.B. 4·91; Ossett M.B. 4·90; Dodworth U.D. 4·76; Ripon and Pateley Bridge R.D. 4·64; Darton U.D. 4·61; Earby U.D. 4·61.

Under the Authority's scheme, 9,272 children were immunised against whooping cough during the year and, since the commencement of the scheme in 1952, a total of 32,365 children have been immunised.

The County Council's scheme for whooping cough immunisation remains unchanged from previous years. Single vaccine is provided at the expense of the Authority as the Ministry do not issue it free as in the case of diphtheria prophylactic. No doubt the Ministry will also provide whooping cough vaccine for the use of Local Health Authorities when they are satisfied that the trials still proceeding have demonstrated the best form for its use.

Diphtheria

The year 1955 proved to be the first ever recorded in which no confirmed case of diphtheria occurred in the Administrative County. The decrease in the number of notifications in recent years has been dramatic and it is interesting to note that the short period covered by the table given below includes both the highest and lowest incidence recorded:—

Year	Number of corrected notifications	Number of deaths	Year	Number of corrected notifications	Number of deaths
1935	3,175	209	1946	551	17
1936	2,261	150	1947	221	4
1937	2,337	138	1948	153	9
1938	2,560	142	1949	66	5
1939	1,983	95	1950	32	1
1940	1,896	110	1951	10	—
1941	1,996	104	1952	4	—
1942	1,686	85	1953	1	—
1943	1,539	75	1954	4	2
1944	1,130	49	1955	—	—
1945	862	30			

The number of children who received immunisation during 1955, together with figures for previous years, are shown in the following table:—

Year	No. of children who completed a full course of immunisation			No. of children who were given a reinforcing injection
	Under 5	5-14	Total	
1948	20,958	6,220	27,178	19,274
1949	20,728	7,162	27,890	18,071
1950	14,836	3,961	18,797	13,929
1951	16,606	5,567	22,173	17,092
1952	15,798	5,298	21,096	23,390
1953	13,768	4,893	18,661	22,614
1954	15,207	5,013	20,320	22,515
1955	13,566	4,516	18,082	18,663

It will be noted that there was an appreciable fall in the number of children immunised during 1955, the total of 18,082 being the lowest figure recorded in any year since the end of the War. The number of deaths from diphtheria has not reached double figures in any one year since 1946 and low mortality makes the task of convincing parents of today of the necessity to maintain a high level of immunisation in the child population more difficult as each year passes. The main difficulty lies in dealing with the young child, particularly under one year of age. The aim should be immunisation of seventy-five per cent. of children before their first birthday, but at the end of 1955, out of 23,760 children of under one year of age, 1,781 only (7.5%) had been immunised.

It is not until some children enter school that it is possible to make arrangements to immunise them and then the overall immunisation state of the child population begins to improve, as is shown in the following table which gives particulars of the immunisation state of the child population as at the 31st December each year for the years 1948 to 1955.

NUMBER IMMUNISED

Year	Under 5	% of population 0-4	5-14	% of population 5-14	Total under 15	% of population 0-14
1948	59,795	44.1	139,194	65.0	198,989	56.9
1949	64,811	46.7	143,966	65.8	208,777	58.4
1950	66,484	47.9	150,179	67.1	216,663	59.7
1951	66,077	47.4	150,177	70.1	216,254	61.5
1952	60,885	46.4	177,875	74.8	238,760	64.7
1953	54,304	42.9	198,151	81.4	252,455	68.2
1954	55,990	45.2	217,052	87.5	273,042	73.4
1955	53,180	43.6	224,126	88.3	277,306	73.8

Measles

Notifications of measles in 1955 numbered 29,357 and there were 4 deaths. Biennial epidemic has been more or less sustained consistently since the notification of the disease began in 1940 and following the "trough" year of 1954 with only 5,558 notifications, the total for 1955 is the highest recorded for a number of years. Mortality statistics in themselves do not reveal all the damage done by measles but in recent years the virus has shown a reduction in virulence and modern drug therapy has done much to mitigate the severity of its sequelæ. To-day, more and more parents are realising the dangers of untreated cases of measles and it is thought that, now there is no financial barrier, medical attention is sought more promptly and frequently.

The disease was most prevalent in the following County Districts: Maltby U.D. with an attack rate of 46·02; Penistone U.D. 43·05; Rothwell U.D. 38·05; Goole R.D. 32·82; Silsden U.D. 32·04; Queensbury and Shelf U.D. 31·61; Darfield U.D. 31·48; Ripponden U.D. 31·27; Hoyland Nether U.D. 30·82; Dearne U.D. 28·78; Ripon City 28·12; Dodworth U.D. 27·62.

Meningococcal Infection

(Cerebro-Spinal Fever)

The incidence of meningococcal infection, 39 notifications, was slightly less than the previous year and compares favourably with the annual average of 47 during the years since 1950 when this group classification was introduced. There was, as usual, a slight increase in incidence during the winter months but the cases were sporadic. Although in the past overcrowding has been the dominant factor in the spread of the infection, more than half the cases in the county were of children under 5 years of age and it appears that the disease remains mildly endemic with no tendency to becoming epidemic.

Acute Poliomyelitis

This disease was more prevalent in the West Riding in 1955 than it had been since 1947. Original notifications for the Administrative County numbered 364 which, on correction, were reduced to 330, 244 of the paralytic form and 86 non-paralytic.

Poliomyelitis is a disease which should be viewed in its proper perspective. It was first recognised as a clinical entity in this country over 150 years ago but, until the end of the 19th century, most cases were sporadic and such outbreaks as did occur were of limited extent. The disease became more common at the beginning of this century and only then was its infectious nature really recognised. In 1912 poliomyelitis became compulsorily notifiable and in that year there were 24 cases in the County but none was removed to hospital. Apart from the year 1940 in which 153 notifications were received (76 from Harrogate M.B.; 17 Knaresborough U.D.) and years of severe incidence in the country in 1920 and 1938, from which the Administrative County virtually escaped, the disease was not prevalent until the first really country-wide epidemic in 1947, when in the County there were 400 corrected notifications. Since then, there have been widespread outbreaks in 1949 (224 cases in the County) and 1950 (191).

In recent years poliomyelitis, in the minds of the general public, has been associated with muscle paralysis and the use of iron lungs. It is a disease which has aroused dread and should not be regarded lightly yet it should be remembered that, judging from past experience, only 9 or 10 per cent. of all cases are expected to be severely paralysed while 17 or 18 per cent. are expected to have some degree of residual paralysis, which is not likely to prevent them from working.

It would appear that climate and season both have an effect on the epidemiological behaviour of the disease for in temperate regions the disease is more prevalent in summer and autumn whereas in tropical areas cases occur more or less uniformly throughout the year. The reason for this phenomenon is not yet known.

In the Administrative County, prior to the week ended 4th June there had been only 15 notifications, but from then on the incidence increased; the number of notifications in any one week varied from 4 in the week ended 18th June to the peak of 34 for the week ended 3rd September and then after, apart from minor peaks, there was a diminution in the number of cases arising but it was not until the end of October that there was any real recession and confidence could be felt that the outbreak was abating.

Coincident with the increase in the County, notifications in Barnsley C.B. also were more numerous and it appeared that some of our early cases had visited or had contact with Barnsley. The spread of the disease followed no set pattern and only 17 out of the 89 County Districts had no case. It is impossible to formulate any conclusions as to why certain Districts should have a high incidence and yet neighbouring Districts with coterminous boundaries should escape infection and it appears that our knowledge of the epidemiology and virology of the disease is still elementary.

By the end of June it became apparent that the number of cases of the disease in the year was likely to be high and the co-operation of the Press was invited in publishing general advice regarding control measures.

Details of the sex and age distribution are shown on page 20 from which it will be seen that approximately 38 per cent. of the paralytic cases were under the age of 5 years compared with 30 per cent. in the age group 5 and under 10 years and 5 per cent. in the 10 and under 15 years group, the remainder, 26 per cent., being aged 15 years or over. With regard to non-paralytic cases, 27 per cent. were under 5 years of age, 34 per cent. in the 5 and under 10 years of age group, 13 per cent. in the 10 and under 15 years group and 27 per cent. aged 15 years or over.

The disease was more prevalent in the industrial south of the County and the following Districts had the highest incidence per 1,000 population: Mexborough U.D. 1.22; Hoyland Nether U.D. 0.89; Penistone U.D. 0.76; Dodworth U.D. 0.71; Darton U.D. 0.70; Wombwell U.D. 0.69; Darfield U.D. 0.62; Swinton U.D. 0.57.

Medical Officers of Health and their staffs worked exceedingly hard and conscientiously during the outbreak as is clear from the following reports.

Dr. R. S. Hynd, Divisional Medical Officer for Division No. 25 and Medical Officer of Health for the constituent Urban Districts of Cudworth, Darfield, Darton, Dodworth, Royston, Wombwell and Worsbrough, writes:—

"GENERAL FEATURES OF THE EPIDEMIC"

The first case, a four-year old girl living in Darton, was notified on the 7th June, the diagnosis not being established until after the onset of the paralysis and until she had been examined by a consultant-orthopædic surgeon. It is probable that the date of onset of symptoms was around the 15th May. Following this notification, 3 further cases were reported in the week ending the 2nd July, two from the Dodworth district and the third from Darton. By now it was apparent that the disease was assuming epidemic proportions in Barnsley and the surrounding districts, and all the general practitioners were informed and advised to cease immunisations and vaccinations. The peak of the epidemic, as far as the divisional area was concerned, was reached in the week ended the 28th July, when 6 cases were notified. From then it declined gradually and by the second week in October appeared to be over apart from the risk of occasional sporadic cases.

Altogether 40 cases were confirmed during the period of the epidemic with the majority amongst children under 10 years of age. Males were affected more than females in the ratio of 5 : 3. The attack rate for the division was 53 per 100,000 population with the highest rates in Dodworth with 71 per 100,000 population, Darton with 70 per 100,000 population and Wombwell with 69 per 100,000 population. It is interesting that Cudworth alone of the seven Urban Districts in the division escaped the epidemic, a somewhat surprising feature on which comment will be made later.

The disease, in general, was mild and few patients were left with permanent disabilities. Of the 40 confirmed cases, seven were of the non-paralytic type. Of the 33 patients with paralysis 13 were discharged from hospital completely cured and of the remaining 20 cases it is expected that at least 10 will eventually make a complete recovery. Four patients were transferred to an orthopædic hospital for further treatment, at the time of writing (January, 1956) two still remain in Kendray Hospital, and one girl, aged 1 year 8 months, died. This child died from acute lymphatic leukaemia, a diagnosis established in hospital, and while there is no doubt she also had a mild attack of paralytic poliomyelitis, the paralysis affecting the left leg, it was in no way the cause of death or even accelerated it.

The youngest patient was a baby boy aged 5 weeks and the oldest a man aged 35. I must confess that the evidence for the diagnosis of non-paralytic poliomyelitis in the infant of five weeks appeared to me to be insufficient, but I accepted the diagnosis of the Hospital.

SOURCE AND SPREAD OF INFECTION

The source of infection was not traced in any one instance. Two cases occurred in one family, but as there was an interval of five weeks between the first and second cases with the first case in hospital during the whole of this period it is improbable that the one infected the other. None of the other patients had, to the best of their knowledge, been in contact with either a known sufferer from the disease or with a known contact. An up-to-date list of contacts was kept throughout the epidemic and a general exchange of information was maintained with the Barnsley County Borough, with other neighbouring authorities and with authorities at a distance where necessary. All contacts were kept under surveillance for three weeks from the date of last contact and none developed the disease.

It appears probable that the main spread of infection must have been through healthy carriers. If we accept the American evidence that for every case of poliomyelitis of whatever type and however mild, there are during an epidemic at least ten healthy carriers and that for every case with paralysis there are at least 100 healthy carriers, the carrier rate in the Barnsley area during the outbreak must have been exceedingly high. The population of my division plus that of the County Borough is roughly 150,000 contained in an area of 30,000 acres with most of the people working as well as living in the area. Ninety of the population contracted poliomyelitis during the epidemic, 70 of whom were confirmed as paralytic cases which, if we accept the above-mentioned statistics for the ratio of healthy carriers to cases, means that between 1 : 20 and 1 : 170 of the population were carriers at some time or other of the epidemic though not necessarily all at the same time or throughout the period. Even if we admit a lower ratio of carriers to cases there must have been a sizeable proportion of the population carrying the virus, a fact which explains why the general measures taken against the spread of infection had only a limited value.

PREVENTIVE MEASURES

I must first acknowledge the valuable assistance of the Kendray Hospital in informing me by telephone of the admission of a case of poliomyelitis, even where the diagnosis was only suspected, within half-an-hour of admission. It allowed preventive measures to be applied early which greatly increased their value.

1. *General Measures.*—These included an immediate home visit by either myself or my deputy. We found this practice worthwhile in that it impressed on the family the concern of the Health Department. It further helped in contact tracing and preparing the family for the necessary restrictions and further surveillance by Health Visitors. Terminal disinfection was carried out by the Sanitary Inspectors. The general preventive measures applied were in accordance with the recommendations of the Expert Committee of the World Health Organisation on Poliomyelitis. Quarantine of the family, as far as practical, was applied for three weeks and schoolchildren were excluded from school for the same period. Adults were not excluded from work unless their work was in the food trade or involved close association with children. The only adult it was necessary to exclude was a schoolteacher whose daughter contracted poliomyelitis.

2. *School Restrictions*.—When it appeared probable that an epidemic of poliomyelitis had begun school restrictions were applied with the knowledge and agreement of the Chairman of the Executive Committee and the Divisional Education Officer, the measures taken being reported to the Executive Committee at its next meeting. The restrictions again were in accordance with the World Health Organisation recommendations and included a ban on strenuous exercise, organised sports and swimming. At the same time the need for strict hygiene, e.g. washing of hands after a visit to the toilet, was emphasised and head teachers were asked to co-operate. The visit of the children to the Bewerley Park Camp School was cancelled.

3. *Swimming Baths*.—Swimming baths in the area were not closed to children as closure would have probably led to an increased use of the many canals in the area. A special watch however was kept on the efficacy of the chlorination plants.

4. *Cinemas—Children's Matinees*.—No attempt was made to close the Saturday morning cinema session for children for much the same reason as applied to the swimming baths. The wise parents automatically excluded their children from the cinema, to close the Saturday morning cinema to the others would have certainly meant the over-crowding of the adult evening performances.

5. *Advice to Local Voluntary Organisations*.—Numerous requests were received from local voluntary associations for advice on whether such annual events as galas, sports meetings, summer camps, etc., should be held or attended if the particular event was outside the area. No routine ban of such events was ever contemplated but each event was considered on its merit and appropriate advice given which in every instance was accepted without question or fuss.

6. *Press Reports*.—Considerable prominence was given, both by the National as well as the Local Press, to the epidemic of poliomyelitis in the Barnsley area, and while some of the reports published were sensational rather than factual, others, particularly in the Local Press, were helpful and were the means of spreading much needed propaganda amongst the general public. The various recommendations of the World Health Organisation Committee all found their way into the local newspapers, the public were kept informed of the situation without being unnecessarily alarmed and the work of the health department was in the main made easier by the publicity given to the epidemic. The publicity included a statement on the early symptoms of the disease and as was to be expected the family doctors had to deal with hundreds of people requesting a precautionary check-up on their health.

DISCUSSION

The epidemic of poliomyelitis brought out many interesting points which are worthy of record. The disease was relatively mild, no death attributable to the disease was reported and the number of patients left with residual paralysis was remarkably few.

The first reported case was undiagnosed until the active stages of the disease were over and the paralysis well established. The disease assumed epidemic proportions in a very short time with the result that the general practitioners were soon on their guard for the early signs of the disease and most cases were diagnosed, or suspected, in the early stages. The hospital arrangements, both for admission and treatment, were excellent throughout the epidemic.

In the spread of infection a remarkable feature was the absence of cases among known contacts with the disease and absence of two or more cases in one family. It seems highly probable that the main source of infection was the healthy carrier, large numbers of whom must have freely circulated amongst the population.

Immediate segregation in hospital of all cases and surveillance of contacts for a period of three weeks was practised, but wholesale exclusion from work of adult contacts was not ordered in view of the large number involved and the disabling effect it would have had on the industrial life of the community. All school children were excluded from school but the only adult excluded from work was a schoolteacher whose daughter contracted the disease. No restriction was ever imposed which was unlikely to be obeyed voluntarily and which could not be enforced. The interest and the co-operation from the general public was, however, very commendable throughout the whole period of the epidemic.

Perhaps the most interesting feature of the epidemic, for which I can offer no satisfactory explanation, was the freedom of the Urban District of Cudworth from the disease during the epidemic period. The district has an estimated population of 8,770 and lies in the north-east portion of the division contiguous with the Urban Districts of Royston, Hemsworth and Darfield and the County Borough of Barnsley, all of whom reported cases. While a good bus service for the district to Barnsley and neighbouring areas is available most of the population work within the boundaries of the district or in the coal-mines immediately adjacent to the district at Carlton, Monk Bretton and Grimethorpe. No cases occurred in the first two districts and only two cases were reported from Grimethorpe. The explanation for the absence of the disease in Cudworth may be that because of insufficient opportunities for contact among the inhabitants with cases or carriers, the carrier rate never became high enough to start an epidemic. This thesis is not particularly strong, but it offers an alternative explanation to that of good fortune and pure chance.

The epidemic, I think, clearly proved the limited value of general preventive measures when applied to the population. Immediate segregation of cases or suspected cases in hospital proved easy, but the complete surveillance of contacts, if normal industrial commitments were not to be unduly upset, was always difficult. Perhaps the greatest obstacle to prevention was the probable large numbers of unknown healthy carriers circulating freely amongst the population. The true prevention of epidemic poliomyelitis must rest in the production of a satisfactory prophylactic and the maintenance of a high level of immunity in all ages of the population."

Commenting on the outbreak in the Mexborough Division (Conisbrough, Dearne and Mexborough Urban Districts), Dr. B. R. A. Demaine, the Deputy Divisional Medical Officer, writes:—

"Up to and including the week ended 12th November, 1955, a total of 36 notifications of poliomyelitis was received in respect of the Conisbrough, Mexborough and Dearne Urban Districts. The distribution of cases in the Division was as follows:—

Mexborough U.D.	22 Notifications	
	Confirmed cases—Paralytic:	11
	Non-Paralytic:	9
Conisbrough U.D.	5 Notifications	
	Confirmed cases—Paralytic:	4
	Non-Paralytic:	1
Dearne U.D.	9 Notifications	
	Confirmed cases—Paralytic:	8
	Non-Paralytic:	1

It should be noted that Mexborough had a total of 22 notifications, with an attack rate of 1.16 which was the highest in the country. Of the confirmed cases in Mexborough these were distributed as follows:—

Under school age	...	...	...	...	3 Paralytic, 1 Non-Paralytic.
Children of school age	...	...	...	...	4 Paralytic, 8 Non-Paralytic.
Adults	...	...	...	...	4 Paralytic.

It was not found possible to draw any firm conclusions as to the possible source of infection and the mode of spread, but the following points are of interest:—

The first case notified in Mexborough, which proved to be the most serious, occurred in a child aged 6 and was notified on the 13th July, 1955. At the present time, December, 1955, this girl is still in Orthopaedic Hospital but is now walking in a double caliper splint.

Secondly, it was noted that there were cases notified amongst children in streets adjoining or near to the 5 recreation grounds in the town. Three of these are provided with conveniences, but no facilities are available for washing hands. Additionally, sandpits are provided in each of the playing-grounds. Five of the children in any case were playmates, and the possibility is that they infected each other.

Mrs. 'N' was notified as suffering from poliomyelitis (paralytic) on the 20th July, 1955, and during her stay in hospital, it was arranged that her young children should be boarded out with her in-laws at another address. Mrs. 'N' was discharged from hospital on the 9th August, 1955, and on the 20th August, 1955, her 18-year-old brother-in-law, who was resident at the address where the children had been boarded out, was notified as a case of paralytic poliomyelitis.

In another case, a boy aged 4 was notified on the 14th September as a case of non-paralytic poliomyelitis, and 7 days later a woman, aged 33, living next door but one was admitted to hospital and the diagnosis was confirmed as paralytic poliomyelitis. So far as it could be ascertained, no personal contact between the infected persons could be established.

It was also observed that during the 3 weeks following the St. Leger Race Meeting at Doncaster, 9 cases of poliomyelitis were confirmed in Mexborough, 1 in Conisbrough and 3 in Dearne. The schools also resumed on the 5th September, 1955 (Monday of Race Week) after the summer holidays, thus increasing the risk of spread.

Although Mexborough has carried a higher number of cases than the neighbouring towns, the populations are of equal standards. The town is densely populated with a population of nearly 19,000 in an area of 1,452 acres; several areas are marked for slum clearance, and the atmosphere is super-charged with soot and sulphur-dioxide. It is, however, on the direct bus route from Barnsley, where a similar outbreak occurred, and there are daily direct supplies of milk and meat from Barnsley into Mexborough. The station is also the rail junction for services to and from Barnsley.

Routine preventive measures were taken as follows:—

On receipt of notifications of a suspected case of poliomyelitis, a visit was made to the house by the Sanitary Inspector and the Health Visitor, and all immediate child contacts were excluded from school for 3 weeks and home and garden quarantine recommended. Parents of other child contacts were advised to call in their Doctor immediately should the child appear unwell, and lists of contacts were supplied to General Practitioners in the Area. Disinfection of the house and school premises was carried out. It was also necessary to recommend the exclusion from work of 4 adults who were immediate contacts of cases, as in three cases they were directly concerned in handling food supplies to the public, and the fourth adult was a school teacher. Due to the generosity of their employers, they suffered little financial loss as a result of their exclusion from work.

Immunisation was stopped both in schools and clinics, and any unnecessary gatherings or functions at schools such as harvest festivals and jumble sales were cancelled. Arrangements were also made with the District Council for suitable warning notices to be posted alongside the rivers and canals advising people not to bathe in these waterways.

Most of the cases in the Division as a whole were of a mild nature, and only in a very small minority of cases have there been any reports of serious residual paralysis. In general, the school-children affected have now returned to school and are leading a normal active life."

With regard to Division No. 22 comprising Hoyland Nether, Penistone and Stocksbridge Urban Districts and the Rural Districts of Penistone and Wortley, Dr. J. Main Russell, Divisional Medical Officer, has provided the following information:—

"The attack rates in the Districts comprising my Division were Hoyland Nether U.D. 0.89 (14 cases); Penistone U.D. 0.76 (5 cases); Penistone R.D. 0.55 (4 cases); Wortley R.D. 0.35 (16 cases) and Stocksbridge U.D. 0.29 (3 cases).

SOURCE OF DISEASE

It is extremely difficult to be dogmatic in this respect, for it is evident that the disease appeared in the Hoyland Nether Urban District and in Wortley Rural District very soon after its appearance in the Barnsley Kendray Hospital catchment area (one must not confuse Barnsley County Borough figures with those for the total of Barnsley County Borough and the surrounding area). At that time, i.e., towards the end of June, the weather suddenly became hot and dry, after a period of cold and wet. There was an immediate movement of population, e.g. holiday travel, school outings, etc., all encouraging the intermixing of the population.

In this Division there was a steady rise in the incidence from the 30th July to the 13th August, which was noticed principally in the Hoyland Nether Urban District, and to a lesser extent in the Wortley Rural District. The figures from the Registrar-General's returns showed that the high incidence appeared in Sheffield during the week following. It would indicate, therefore, that there had been a spread of the infection from that part of the Administrative County of the West Riding surrounding Barnsley, through Division 22 to the County Borough of Sheffield. Stocksbridge had 2 cases during that period, which is consistent with the flow of the infection from North to South, whilst Penistone seems to have remained fairly stable in its numbers, although its first appearance in both Urban and Rural Districts was early in August. The source of the infection would appear, therefore, to be in the West Riding County, north of Barnsley.

CONCLUSIONS FROM INVESTIGATION OF CASES

It is very difficult to point to any one factor as a mode of spread, but I have analysed the cases in the Wortley District and find that 6 visited seaside resorts ranging from Rhyl to Blackpool in the West, and to Cleethorpes and Mablethorpe in the East. In one or two instances there were school trips which took the children abroad and to London. In 8 cases there was a definite history of joining with crowds of people and the necessary bus travel consequent upon this mixing together. In 2 cases, however, there could have been no possible contact with an outside healthy carrier as the two patients involved had not mixed with anyone other than those at home.

With regard to Hoyland Nether Urban District, the same kind of picture applies. In 4 cases there were visits made to parts of the country ranging from Huddersfield to Rhondda Valley, and in one instance to Dublin. In the case of Hoyland, however, there was a very close tie-up with Barnsley County Borough and its surrounding district.

I think we can dismiss the Stocksbridge and the two Penistone Districts, as the numbers are too small to draw any conclusion at all.

It is a point, in considering this travelling about the country, that in those cases where there was a history of long journeys the incidence of paralytic cases was very much lower than in the other group. This might just be a coincidence, and of no significance whatever.

On talking about the poliomyelitis incidence with General Practitioners I was informed on one or two occasions that there appeared to be quite a fair amount of indefinable minor illnesses, principally amongst the younger population. These conditions were variously labelled 'Flu,' 'Rheumatism,' 'Gastric Influenza,' and in one or two cases 'Mild Meningism.' It was suggested that these might very well have been abortive cases of poliomyelitis. Having this in mind (and it is very probable that they were abortive cases of poliomyelitis) there would be quite a number of infective persons about who would be disseminating the organism, not only by droplet spread, but by breakdowns in personal hygiene principles from infective faeces.

The control measures adopted generally were that I made a personal visit to each home (except in 4 instances only) and explained the dangers to the family. Those who were involved in work which might mean a dangerous spread of infection, e.g. shops, busy offices, or in school, were advised to change their job for the time being where they would have less close contact, or alternatively to stay at home. All children contacts were asked to maintain a house and garden quarantine and exercise strict personal hygiene principles. I pointed out in every case that it was only a question of being sensible and applying common-sense principles to their mode of life for the next week or two. I am glad to say that in every case I got the fullest co-operation and I think it was this concern on the part of these contacts to limit the possibility of any spread of infection that did, in fact, keep the incidence as low as it was.

Every opportunity was taken in schools and in clinics, and whenever I met groups of the population, to advise that if there was any illness in the family, medical advice should be sought immediately. From time to time I was asked about disinfection of bedding, clothing, etc., and in those cases where it might be of some psychological benefit the Sanitary Inspector's Department did some token spraying of the premises. I find that in circumstances such as these it is very wise to fall in with some of the requests of the relatives and contacts, even to such things as spraying rooms and issuing disinfectant."

The disease was also prevalent in the neighbouring Division comprising the Districts of Hems-worth Urban and Rural and Dr. J. S. Walters, the Divisional Medical Officer and Medical Officer of Health, writes:—

"I regret that I am unable to draw any firm conclusions from my investigations.

Of 21 cases notified, 16 proved to be positive (13 paralytic and 3 non-paralytic). One case, a male aged 16 years of age, occurred in March and did not appear to be associated with any other case in the Division or in the surrounding districts although he did, in fact, work in Barnsley. Subsequent cases occurred at the end of June, the end of July, with the heaviest incidence during August and the first week in September. There was no case in October and one case in November.

With one exception, viz.: the first case, all those affected were eight years of age or younger and there was no second case in any one household nor was there direct contact between any two cases.

Because the children affected were all young and not likely to have travelled far from their homes it would seem that they contracted their illness from healthy carriers and/or missed abortive cases. I think it unlikely that there were many missed cases because the general public and the local practitioners were all aware of the outbreak in the Barnsley area and were on the alert. The incidence of cases in the various parishes does not support a direct geographical connection with Barnsley.

The control measures used were visits to the households where the cases occurred and advice on hygiene, with special emphasis on hygiene of the toilet. Household contacts of school age were excluded and in one case the father of the affected child, who was a teacher, discontinued teaching after consultation with his medical practitioner."

The year 1955 will be remembered as being a year of outstanding importance in the development of vaccines for protection against the disease. Some millions of children in America and Canada were inoculated with the Salk vaccine which emerged after years of careful and patient research and is a milestone in medical progress.

In January, 1956, the Ministry of Health issued Circular 2/56 regarding proposals for the immunisation of children against the disease, and while it would be premature to assume that the final answer to the problem has been found, this new development gives great promise that a sure advance will be made towards the conquest of poliomyelitis.

Acute Encephalitis

Six confirmed cases were notified during the year, two of which were infective and four post-infectious, and compare favourably with eight cases in 1954 and ten in 1953. The disease is difficult to diagnose and often is only identified after the death of the patient. The post-infectious form may include cases of encephalitis associated with one of the commoner infectious diseases but it is difficult to assess the danger of this complication since, by international coding, any deaths are classified to the primary infection concerned.

Dysentery

In 1955, the number of cases of dysentery, 1,310, was the second highest on record exceeded only by the 1,454 cases notified during 1954. The high incidence is not peculiar to the County but is common to other northern counties. Although it would appear that more efficient notification of dysentery and an increased interest in the disease generally may have contributed to the increase in notifications in recent years, it is clear that the disease is becoming more prevalent. The disease, for the most part, was mild and the majority of cases were of *Sh. sonnei*.

The distribution of cases in the different quarters of the year is interesting but difficult of explanation, notifications by quarters and sex being as follows:—

	M.	F.	Total
1st Quarter	79	99	178
2nd Quarter	145	138	283
3rd Quarter	68	68	136
4th Quarter	404	309	713

While the figures do not represent the true incidence, the disease appears to be rarely conveyed by food but that direct or indirect personal contact is mainly responsible. Many of the notified cases arose in nurseries, children's hospitals and schools, but there was also a marked increase in families and symptomless excretors by no means played a small part in the spread of the disease.

From the following table it will be seen that the percentage of notifications in various age groups does not fluctuate unduly from year to year but the disease is probably more prevalent in adults than is shown by the notifications.

Notifications in various age groups.

Age (years)	1952 per cent.	1953 per cent.	1954 per cent.	1955 per cent.
Under 5	34.6	34.1	37.8	32.4
5 and under 15	40.5	35.6	34.0	35.5
Total under 15	75.1	69.7	71.8	67.9
15 and under 45	13.8	19.8	20.8	21.6

The importance of thorough cleanliness, both personal and in the preparation and handling of food, which, coupled with hand washing immediately after visiting the toilet, remain the principal safeguards against all forms of dysentery.

Dysentery was especially prevalent in the Kirkburton Urban District and Dr. E. Ward, Divisional Medical Officer for Division No. 20 and Medical Officer of Health for the constituent Urban Districts of Colne Valley, Denby Dale, Holmfirth, Kirkburton, Meltham and Saddleworth writes:—

“During the year, 237 cases of Sonne Dysentery were notified in the Division, as compared with 45 in 1954. Of these cases, 177 were notified in the Kirkburton Urban District, 46 in Saddleworth, 7 in Denby Dale, 4 in Colne Valley and 3 in Meltham. No cases were notified in Holmfirth.

The Kirkburton cases occurred in three groups. In the spring 10 cases came to notice in the Lepton/Almondbury area. These were closely associated with one another and infection was probably imported by school children from a school just over the district boundary, where at this time the disease was prevalent. The family principally affected was engaged in milk production so arrangements were made for the milk produced to be heat treated.

The second group of 8 cases occurred in July in Kirkheaton. Again the cases were closely related.

The most extensive was in Kirkburton village and first came to notice early in November when the Head Teacher of the Kirkburton Church of England School reported that during the previous fortnight some 20 or 30 children had been absent from school, each for a few days, suffering from sickness and diarrhoea. Particulars of the absentees were obtained from the Head Teacher and visits were paid by the Sanitary Inspector to the three most recent cases and specimens were obtained for examination. These were reported by the Public Health Laboratory, Wakefield, as being positive for *Shigella Sonnei*. On receiving this information the Sanitary Inspector visited the school and obtained a list of from 50 to 60 children who had been absent the previous fortnight suffering from diarrhoea or who were contacts of such children. Some 56 specimens were obtained and 50 of these were later reported as positive for *Shigella Sonnei*.

In the meantime General Practitioners in the area were contacted and informed of the results of the faeces examination. Information was obtained to the effect that cases of diarrhoea had been occurring in the district for some weeks past but no specimens had been sent in for examination. The cases had cleared up clinically quite quickly following treatment with one of the sulpha drugs.

From the information available it was apparent that a widespread outbreak of Sonne Dysentery was in progress in the school. Enquiries were made from the canteen staff at the school as to any intestinal disturbances but none was admitted. An examination of faeces, however, showed that two of the women working in the canteen were excreting *Shigella Sonnei*. One later admitted having had slight diarrhoea a week previously but did not stay off work. The other woman found to be excreting did not give any history of diarrhoea.

All children attending the school who gave a history of diarrhoea, and their contacts were forthwith excluded from school until a specimen had been examined. In the case of infants 3 negatives were required from both cases and contacts before return to school was allowed, but in the case of children over 8 years return was allowed when one negative had been obtained, 2 further specimens being examined after return to school.

Contacts who were food handlers were excluded from food handling duties until one negative was obtained, 2 further specimens being obtained after return to work.

During November new cases were found in decreasing numbers as shown in the following table:—

Week Ending	12.11.55	—	92
“	19.11.55	—	42
“	26.11.55	—	13
“	3.12.55	—	10
“	10.12.55	—	2
“	17.12.55	—	1
“	24.12.55	—	1
“	31.12.55	—	-

The majority of cases were children attending the Church of England School which is a Junior School but some of the contacts who became infected were pupils at the Secondary Modern School.

In all some 155 cases were notified and accepted as confirmed cases. The age distribution of the cases is shown below:—

Years							
0—2	2—5	5—8	8—12	12—15	15—25	25—45	Over 45
7	20	39	31	8	9	31	10

From 123 of these *Shigella Sonnei* was isolated.

As soon as the size of the outbreak became apparent, Dr. Little of the Wakefield Laboratory kindly investigated specimens from 10 patients for susceptibility and reported as follows:—

'Specimens were *sensitive* to Chloramphenicol, Streptomycin and Terramycin, *slightly sensitive* to Aureomycin and *resistant* to Penicillin, Erythromycin and sulpha.'

This information was passed on to General Practitioners concerned and treatment with Streptomycin in the form of Guanimycin was carried out in the majority of cases.

The fact that the organism was resistant to sulpha drugs probably accounted for the high percentage of children who were found to be excreting after having apparently recovered from the disease following treatment with one of the sulpha drugs.

The majority of cases ceased excreting after one course of treatment with Guanimycin but some persisted for several weeks as is shown in the following table:—

Period from 1st positive specimen to 1st negative specimen in the final series.

Under 2 weeks	2—3 weeks	3—4 weeks	4—6 weeks	6—8 weeks	8—10 weeks	10—12 weeks	12—14 weeks
37	33	23	20	2	3	4	1

Throughout the outbreak, there was excellent liaison between the General Practitioners, the Head Teacher of the school concerned and the Sanitary Inspectors and I feel that it was largely due to their goodwill and ready co-operation that the outbreak was cleared up so quickly.

The 7 cases in the Denby Dale area were all members of one family, one child of which attended the Kirkburton Secondary Modern School, thus providing the direct link with the Kirkburton outbreak.

The 46 cases in Saddleworth Urban District occurred mainly in the late spring and early summer. In most instances there was some connection, usually through school children, with Oldham, where at the time, an extensive outbreak of dysentery was in progress. No particular school or locality was principally involved.

The 4 cases in Colne Valley were 2 isolated cases and 2 members of the same family, whilst the 3 cases in Meltham were all members of the same family."

Castleford M.B. and Normanton U.D. also had a high incidence and Dr. J. M. Paterson, Divisional Medical Officer and Medical Officer of Health for these Districts, has provided the following information:—

"During the year there were two outbreaks of Sonne Dysentery, one in Castleford, the other in Normanton, and so far as could be ascertained the one was quite unrelated to the other. In both outbreaks those affected suffered from symptoms of vomiting and sickness, colic, diarrhoea and a tendency to become temporary carriers for varying periods of time—in some the duration of this phase was as long as 42 days. During both of these outbreaks it was found, as would be expected, that a varying percentage of the general population became symptomless carriers, though of the two this was a more noticeable feature in the Castleford outbreak. Whilst it was possible to get a fairly reliable index of the extent of the infection among school children, the position became very involved in the case of the adults infected. In view of the sudden onset of the disease and its rapid decline, it can readily be imagined that the average adult would either not seek medical treatment at all or, if he did, promptly cease it with the subsidence of the symptoms. Thus our epidemiological records are inclined to be sketchy. Contrary to general expectation, the use of the sulpha group of drugs or a combination of the sulpha drugs and antibiotics did not appear to eliminate the organism from the faeces and it was particularly noticeable that in our attempts to get three negative faeces samples, anomalous bacteriological results were not infrequently obtained. Thus it was not uncommon after obtaining one or even two negative faeces bacteriological results to get a positive one or indeed even to get a superimposed salmonella infection with apparently no untoward results.

In the Castleford outbreak I obtained the co-operation of Dr. Little, Medical Director of the Medical Research Council Laboratory, Wakefield, to track down the basic source of the infection in the schools affected but in spite of the extensive sampling most of the information turned out to be of a negative character. In two instances a positive swab was obtained from infected lavatory seats. To prevent the general spread of infection, whilst at the same time keeping in mind the menace of the symptomless carrier, called for the institution of an intensive system of personal hygiene, and any success in this direction demanded that there should be a close liaison between the officers of the Health Department and the teachers. Needless to say they rose to the occasion and a unit towel system was introduced whereby each child was provided with a towel or, if that was impracticable, with a paper one. In addition, suitable disinfectants were also provided. The main purpose of these precautions was to ensure that each child washed its hands after a visit to the toilet or before a meal. Instructions were also given regarding the action that should be taken in regard to communal articles used in school and the segregation of acute cases. Food handlers and canteen workers were, of course, excluded until it was ascertained that any existing infection had been completely eliminated, and there is no doubt whatsoever that all these precautions had a most salutary effect in limiting the further spread of the disease.

In Castleford the infection commenced about the middle of March and continued until June. Originally the outbreak appeared to be limited to the Redhill Infants' School where it first appeared on the 18th March, but it was subsequently notified in the Airedale Infants' and still later in the Airedale Junior and Secondary

Modern Schools. It was evident during this infection that a considerable number of the adult population was similarly afflicted though the actual number of notifications received was small. Thus the total number notified was 55, of whom 14 were under school age, 27 of school age and 14 adults. Though there were 55 cases notified, other cases were discovered during investigations making, in all, 92 bacteriologically confirmed cases.

In the Normanton outbreak which first came to light towards the end of October, the infection was concentrated mainly on the Normanton Common Infants' and Junior Schools. The outbreak had not completely subsided by the end of the year, and the position at 31st December was 34 cases notified, 8 of whom were under school age, 23 of school age and 3 adults. As in the outbreak at Castleford, further cases were ascertained during the course of investigations. As a result of these investigations the number of bacteriologically confirmed cases totalled 63.

METHODS ADOPTED TO PREVENT THE SPREAD OF INFECTION IN SCHOOL

1. Lavatory seats were regularly cleansed by means of a disinfectant.
2. An adequate supply of paper towels was distributed and a regular system of hand washing drill instituted, after visits to the toilet, before meals, etc.
3. Toys, etc., commonly found in Infants' Schools as well as articles of a communal nature found in both Infant and Junior Schools were thoroughly disinfected, and the floors of the schools were effectively sluiced with disinfectant.
4. Teachers, canteen workers, food handlers at school, if found to be infected, were excluded until three negative faeces samples were obtained.

CONCLUSIONS

1. The experience gained from this and other outbreaks of Sonne Dysentery reveals how scanty is our knowledge of the impact of certain pathological bacteria on the normal bowel flora compatible with apparent good health.
2. There would appear to be some irregular time factor periodicity acting as regards outbreaks of Sonne Dysentery.
3. The index of the extent of Sonne Dysentery outbreaks is readily obtained in school children but even although these outbreaks may be and usually are fairly widespread among the adult population, they mostly remain undiagnosed.
4. The rapid onset of the disease and the equally rapid decline handicap General Practitioners in sending bacteriological faeces samples.
5. To get a true evaluation of the extent of this condition much more field-work will have to be carried out."

Ophthalmia Neonatorum

Ophthalmia neonatorum is defined in the Regulations as "a purulent discharge from the eyes of an infant commencing within 21 days from the date of its birth" and unless prompt, skilled treatment is given it could lead to impaired vision or even total blindness. The incidence of the disease is decreasing and the total of 15 cases notified during the year is the lowest ever recorded for the Administrative County. Vision was unimpaired in all cases.

Puerperal Pyrexia

Since the new regulations re-defining puerperal pyrexia came into force in 1951, the number of notifications has been slightly higher than previously. A total of 136 cases was notified in 1955 and, while this is an increase of 5 over the previous year, it is less than the average for the four preceding years.

In the lay mind puerperal pyrexia is construed as meaning puerperal fever which is incorrect, for it only relates to any pyrexial state without regard to clinical cause, e.g., of which an inflammatory condition of the breast would constitute a notification.

The definition was accordingly amended to read "puerperal pyrexia means any febrile condition occurring in a woman in whom a temperature of 100.4°F. or more has occurred within fourteen days after childbirth or miscarriage" and came into operation as from 1st August, 1951.

In order that information may be available to assist Medical Officers of Health in distinguishing cases in which epidemiological action may be necessary, a new notification form requiring the cause of the disease, if known, to be stated was prescribed under the Puerperal Pyrexia (Amendment) Regulations, 1954, which came into operation on 1st March, 1955.

Smallpox

Freedom from smallpox continued in the Administrative County during 1955. Prior to the 14 cases in 1953, there had been no notification since 1938 and its disappearance no doubt led to a lessening fear of the disease. In these days when air travel brings this country close in time to those parts of the world in which smallpox is still endemic, the failure to secure a high proportion of the population who are protected by vaccination may lead to serious consequences.

Vaccination against Smallpox.—Vaccination is offered to the parents or guardians of all children during the early months of life and is carried out either by the family doctor at the surgery or in the home, or by the Medical Officer at the Infant Welfare Clinic.

The following table shows the number of vaccinations and re-vaccinations performed during the years 1952-1955:—

Year	Vaccinations						Re-Vaccinations					
	Under 1	1	2-4	5-14	15 or over	Total	Under 1	1	2-4	5-14	15 or over	Total
1952	3,803	1,368	479	373	1,042	7,065	25	7	23	136	1,273	1,464
1953	6,556	2,901	6,770	24,611	29,166	70,004	32	58	842	8,680	36,266	45,878
1954	5,379	1,019	351	424	797	7,970	—	1	44	245	1,238	1,528
1955	6,329	1,294	376	282	612	8,893	1	8	56	163	1,226	1,454

One case of generalised vaccinia was reported. The general reaction was small and the lesions cleared up without incident.

Following upon receipt of Ministry of Health Circular 6/55 dated 6th April, 1955, the contents of which were discussed at one of the monthly meetings of Divisional Medical Officers, it was decided that the co-operation of general medical practitioners should be sought and to this end the matter was discussed at a meeting between Medical Officers of the Local Health Authority and representatives of the general medical practitioners on the Executive Council. The outcome of this meeting was that a personal letter from the County Medical Officer was sent to all general practitioners practising in the Administrative County inviting their help in increasing the number of infant vaccinations, as follows:—

“The Ministry of Health in a recent circular which was quoted in the Memorandum to all medical practitioners issued by the Executive Council of the West Riding of Yorkshire on the 18th April, 1955, stresses the importance of primary vaccination in infancy and of re-vaccination in later years.

In England and Wales in 1954, the percentage of infants under one year of age who were vaccinated was approximately 34.5; the percentage in the West Riding Administrative County was approximately 22.3. I should like to see a great improvement in this figure.

I enclose a copy of the form of consent to vaccination which is used by this Authority and usually left at the home for the use of parents when the Health Visitor makes her visit to a recently born infant. At subsequent visits the Health Visitor will endeavour to persuade the parents to agree to the vaccination of their child, either by the family doctor or at the Infant Welfare Centre.

I am writing this letter to you to ask for your help in increasing the number of infant vaccinations. In your position as family doctor you will have unrivalled opportunity to advocate the value of, and to carry out vaccination at an early age, for you will no doubt be consulted about other immunisation procedures, against diphtheria and whooping cough for example.

If you think it would be of value in drawing the attention of parents to vaccination I could supply a poster (30" x 15") for display in your surgery."

In response to the last paragraph thereof, 100 posters were issued to 67 general practitioners.

It will be noted that the number of vaccinations in 1955 in the "Under 1" group exceeded those for the preceding year by 950 but again the position though improved is by no means as favourable as could be desired.

With regard to the re-vaccination of school children, Circular 6/55 states:—

“The re-vaccination of children within two or three years of first entering school not only maintains or revives their individual protection, but it is likely to facilitate substantially the control of local outbreaks of smallpox. It also ensures that any further vaccination in later life, performed perhaps on entering the Armed Forces or a particular employment or necessitated by travel abroad, will be less likely to have any serious reactions or complications. For all these reasons the re-vaccination of school children is to be encouraged. The Minister would not, however, suggest that it would be necessary for the Authority to provide a direct service for this purpose until the level of infant vaccination has been substantially raised. He considers that, unless the authority particularly wish to make their own arrangements, they should rely in this connection on the services of general practitioners and keep them in touch with what is in mind.”

In view of the present low rate of infant vaccination in the Administrative County, it is not intended to provide a direct service for the re-vaccination of school children, and as suggested in the Circular, reliance will be placed on the general practitioners for the re-vaccination of school children.

As reported in the Annual Report for 1954, provision has been made for vaccination of workers in the cotton industry up to and including the carding room stage as it is thought that they might be at greater risk and an approach has been made, where appropriate, by the Divisional Medical Officers of the areas concerned to the firms who handle cotton in the carding and pre-carding stages. The response has not been good, only 9 vaccinations and 28 re-vaccinations having been reported. Dr. Lyons, the Divisional Medical Officer in the Todmorden Division, reports that the attitude in general, to the scheme, is one of apathy and indifference.

Enteric (Typhoid) Fever

Of the five confirmed notifications of enteric fever which were notified during the year, single cases arose in Featherstone U.D., Harrogate M.B. and Darton U.D. These were straightforward isolated cases and had no apparent connection with any other case.

A case from Osgoldcross R.D., an elderly man, was admitted to hospital for investigation and was subsequently diagnosed as suffering from enteric fever. He was transferred to an isolation hospital but died a few days later. Investigations revealed that his wife was a carrier and she was admitted to hospital for treatment. The other notification was of a nurse at the hospital to which the above man was first admitted. She went to her home in Hemsworth R.D. on her off duty period and shortly afterwards fell ill. She was admitted to hospital for investigation where enteric fever was diagnosed. From the inquiries made it transpired that she had nursed the case previously mentioned and she had informed her mother, and later her doctor, that she felt she was developing typhoid fever especially when diarrhoea set in. Fortunately, the patient's mother was a sensible person who had insisted on all members of the family observing scrupulous cleanliness in personal habits and no further case arose.

Paratyphoid Fever

Of the 25 confirmed cases of paratyphoid fever nine cases from Kiveton Park R.D. formed part of an outbreak which originated in Nottinghamshire.

The first case, a woman of 43 years, was admitted to hospital as a case of dysentery but subsequently, on 1st September, she was found to be suffering from paratyphoid B. infection.

About the same time the Public Health Laboratories at Sheffield and Nottingham discovered that there were cases in the County of Nottingham with para. B. infection who had eaten pork and ham from shops in that area. The medical practitioners in the Kiveton Park R.D. were warned that there might be other cases with this infection in the area and 14 cases in all came to the notice of the Medical Officer of Health and, of these, seven had clinical symptoms and the remainder were symptomless carriers.

These cases were all found to have purchased boiled ham, pigs' fry, bacon, pork pies and potted meat from the same shop situate in Nottinghamshire.

Many of the cases in Nottinghamshire were of mixed infection — paratyphoid B. and salmonella typhi-murium and three other members of the family of the case mentioned above were found to be suffering from typhi-murium.

Apart from a view expressed by Dr. G. D. Hemmes, Medical Officer of Health of Utrecht in Holland, that in his opinion in 1950 in Holland three outbreaks may have been caused by eating the flesh of infected animals and that pigs may be a reservoir of *S. paratyphosa* and can set up epidemics of paratyphoid in man without the agency of a human carrier, all references appear to regard paratyphosus B. as a human organism, although, like most salmonellæ, it has been recovered on occasion from the mesenteric glands of pigs. Nevertheless, on this occasion there appeared to be fairly good evidence that an infected pig may have been responsible for the outbreak and inquiries were made at the premises from which pigs were believed to have been sold to the firm concerned. Dr. J. M. Watt, the Medical Officer of Health, and his staff co-operated fully in the investigation but none of the pig dealers in his area admitted any disease amongst his stock during the month of August.

Throughout the outbreak, close co-operation was maintained with Dr. C. W. W. Jeremiah, County Medical Officer, Nottinghamshire, but in spite of the outbreak being thoroughly investigated, the cause unfortunately remains unproven.

Of the remainder of the cases notified during the year, seven, from Wortley R.D., were sporadic cases and had no apparent connection with each other or the Nottinghamshire outbreak. From Heckmondwike U.D. three notifications were received, two being of a boy ten years old and his mother. During the enquiries by the Medical Officer of Health, Chinese dried egg albumen came under suspicion but proof was not established. The remaining notifications were of sporadic cases in widely separated districts.

Food Poisoning

It is disappointing to record a further increase in the number of cases of food poisoning in spite of the sustained efforts in many of the county districts in organising clean food campaigns. Corrected notifications in 1955 numbered 346, in addition to which there were 53 cases which were not notified but were ascertained during the course of investigations into two outbreaks, making a total of 399 which is the highest recorded total since notification came into general use in 1949. In 1954 there was a total of 385 cases and 366 in 1953.

As for dysentery, notification is far from complete and there may have been a considerable number of mild cases which did not receive medical attention and, consequently, do not appear in the records.

There were 22 outbreaks, including family outbreaks, involving 177 cases in which the causal agent was identified; salmonella organisms were responsible for 17 outbreaks, staphylococci 2 and cl. welchii 2. Outbreaks of undiscovered cause numbered 13 comprising 87 cases, while single cases totalled 135, in 88 of which the causal agent was identified, but were apparently not connected with any outbreak.

During the year imported egg albumen came under suspicion as to its bacteriological safety. Dried egg albumen is used in a variety of ways by the baking and confectionery trades and considerable quantities, mainly in crystalline or powdered form, are imported from China. Much of the product has been suspected to be infected with various types of *Salmonellæ*, including on occasions *S. paratyphi B*, but, fortunately, in the County no outbreak of salmonella food poisoning or paratyphoid fever was proved to come from this source.

To a large extent, food poisoning is preventable and everyone, caterers, food handlers and housewives alike, can play their part in ensuring that all foodstuffs are handled hygienically and prepared and stored in such a way that they are safe to eat.

The relevant statistics for 1955 are given in the following table:—

Division No.	Food Poisoning Notifications returned to R.G. (Corrected)					Number of outbreaks due to Identified Agents						Outbreaks of Undiscovered Cause		Single Cases		
	Quarter of Year				Total	Chemical Poisoning	Salmonella Organisms	Staphylococci (inc. Toxin)	Cl. botulinum	Other bacteria	Total Cases	No. of outbreaks	No. of Cases	Agent Identified	Unknown Cause	Total
	1st	2nd	3rd	4th												
1	—	—	5	5	10	—	2	—	—	—	10	—	—	—	—	—
2	—	5	—	—	5	—	—	—	—	—	—	3	54†	1	—	1
3	—	2	—	2	4	—	—	—	—	—	—	—	—	—	4	4
4	1	36	8	1	46	—	—	—	—	2	42*	—	—	7	—	7
5	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
6	—	—	55	3	58	—	2	—	—	—	51	—	—	—	7	7
7	—	—	3	—	3	—	—	—	—	—	—	1	3	—	—	—
8	6	—	2	—	8	—	2	—	—	—	5	—	—	3	—	3
9	4	—	1	1	6	—	—	—	—	—	—	1	4	2	—	2
10	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
11	—	2	—	—	2	—	1	—	—	—	2	—	—	—	—	—
12	—	—	1	1	2	—	—	—	—	—	—	—	—	2	—	2
13	—	—	4	5	9	—	—	—	—	—	—	—	—	5	4	9
15	—	1	6	2	9	—	—	—	—	—	—	—	—	9	—	9
16	1	2	—	—	3	—	—	—	—	—	—	—	—	—	3	3
17	2	5	2	—	9	—	—	—	—	—	—	—	—	1	8	9
18	—	1	18	3	22	—	—	1	—	—	11	—	—	8	3	11
19	1	—	4	—	5	—	1	—	—	—	2	—	—	—	3	3
20	—	14	8	1	23	—	1	1	—	—	22	—	—	1	—	1
22	1	11	4	7	23	—	2	—	—	—	10	2	6	2	5	7
23	—	1	6	14	21	—	—	—	—	—	—	—	—	21	—	21
25	5	1	2	13	21	—	4	—	—	1	14	—	—	7	—	7
26	—	—	—	2	2	—	—	—	—	—	—	—	—	—	2	2
27	—	1	4	3	8	—	—	—	—	—	—	—	—	7	1	8
28	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
29	—	6	1	4	11	—	—	—	—	—	—	2	7	—	4	4
30	—	3	4	2	9	—	—	—	—	—	—	—	—	8	1	9
31	4	2	8	13	27	—	2	—	—	—	8	4	13	4	2	6
	25	93	146	82	346	—	17	2	—	3	177	13	87	88	47	135

* Includes 3 cases not notified but ascertained during the course of investigations

† Includes 50 cases not notified but ascertained during the course of investigations

Influenza

There was no undue prevalence of influenza during the year and, while the widespread epidemic of influenza type B which occurred in the last quarter of 1954 in the County continued into the first quarter of 1955, it was on a considerably reduced scale.

Towards the end of the year there was the normal winter rise in upper respiratory infections with a few sporadic cases of influenza but no apparent outbreak.

Tuberculosis

Deaths from Tuberculosis.—There were 192 deaths from tuberculosis (169 respiratory and 23 non-respiratory), a reduction of more than one-third in comparison with the 287 deaths recorded last year. The death rate of 0.12 (0.11 respiratory and 0.01 non-respiratory) is compared favourably with the rates for England and Wales of 0.15 (0.13 respiratory and 0.02 non-respiratory). Comparisons with the mortality of ten and twenty years ago reveal not only the increased impetus of post-war developments, but also an accompanying change in the pattern of the age groups as follows:—

	1935	1945	1955
Deaths	891	684	192
Death rate	0.56	0.47	0.12
Percentage of deaths under 45 years of age	50	62	29

Details of the deaths occurring during 1955 are given in the following table:—

Classification	AGE AT DEATH IN YEARS																Total		Grand Total
	0—		1—		5—		15—		25—		45—		65—		75 —				
	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	M.	F.	
Respiratory	—	—	—	—	—	—	2	2	24	17	76	5	27	3	9	4	138	31	169
Non-Respiratory	1	1	1	2	2	1	—	—	1	1	5	3	2	2	—	1	12	11	23
Total	1	1	1	2	2	1	2	2	25	18	81	8	29	5	9	5	150	42	192

Notification of Tuberculosis:—There were 1,198 primary notifications of tuberculosis arising during the year and 40 supplemental notifications, a total of 1,238 as compared with 1,290 (1,244 primary and 46 supplemental) notifications in 1954. Details of the new cases are summarised in the following table.

FORMAL NOTIFICATIONS:—	AGE PERIODS													Total all Ages
	0—	1—	2—	5—	10—	15—	20—	25—	35—	45—	55—	65—	75—	
Respiratory, Males	3	2	18	29	12	51	57	79	81	125	104	38	9	608
Respiratory, Females	1	5	21	19	17	55	69	94	59	18	16	12	6	392
Non-Respiratory, Males	2	1	6	19	15	7	8	8	8	3	3	3	2	85
Non-Respiratory, Females	3	—	10	15	17	10	13	20	8	8	4	3	2	113
														1,198
SUPPLEMENTAL NOTIFICATIONS:—														
Respiratory, Males	—	—	—	—	—	—	1	2	3	3	8	6	4	27
Respiratory, Females	—	—	—	—	—	—	—	1	1	1	—	1	1	5
Non-Respiratory, Males	—	—	1	—	—	—	—	—	—	1	1	1	—	4
Non-Respiratory, Females	—	—	1	—	—	—	—	—	—	2	1	—	—	4
														40

The sources of information of the supplemental notifications were Local Registrars (17 respiratory, 3 non-respiratory); transferable deaths from the Registrar General (6 respiratory, 4 non-respiratory) and posthumous notifications (9 respiratory, 1 non-respiratory).

POSTHUMOUS NOTIFICATIONS.—The 40 cases included in the supplemental notifications have again been the subject of investigation with a view to determining the reason for failure to notify the disease before the death of the patient. The following table illustrates the result of these inquiries.

1. Information Obtained from Local Registrar's Death Returns.

Patient			Cause of Death.	Remarks.
Sex	Age	Resp. or Non- Resp.		
F	65	Resp.	1.(a) Pulmonary tuberculosis. 2 Diabetes Mellitus.	Family doctor failed to notify, incorrectly thinking that the case was already notified.
M	51	Non- Resp.	1.(a) Congestive Heart Failure. (b) Chronic Myocarditis. 2. Tuberculosis of Spine.	Case of long standing. General practitioner presumed case had been notified by his predecessor.
F	60	Non- Resp.	1.(a) Tuberculous Enteritis. 2. Hyperpiesis.	—
M	65	Resp.	1.(a) Pulmonary tuberculosis.	Present doctor took patient over many years ago — already then receiving treatment for pulmonary tuberculosis. Dr. had no reason to believe that it was not already notified.
M	77	Resp.	1. Chronic pulmonary tuberculosis. 2. Tuberculosis of rt. suprarenal gland and liver and impacted stones in the common bile duct P.M.	Not diagnosed until P.M.
M	51	Resp.	1.(a) Pulmonary tuberculosis.	Was first diagnosed as suffering from pulmonary tuberculosis on the 14th February, 1945, when it was believed that the case had been notified.
F	36	Resp.	1.(a) Pulmonary tuberculosis. 2. Disseminated Sclerosis.	Admitted Hospital 22.6.48 from another area, and remained there until her death.
M	72	Resp.	1.(a) Pulmonary tuberculosis.	Oversight.
M	64	Resp.	R. and L. ventricular failure, fibrosis of lung, chronic bronchitis and pulmonary tuberculosis.	Tuberculosis suspected but not notified before death.
M	63	Resp.	Cachexia and Toxaemia from old standing phthisis of the left lung. Certificate received from Coroner.	Diagnosis not made until after post-mortem examination.
M	56	Resp.	1.(b) Pulmonary tuberculosis. 2. Squamous Carcinoma of right cheek.	—
M	67	Resp.	1.(a) Parkinson's Disease. 2. Pulmonary tuberculosis.	—
M	80	Resp.	1.(a) Pulmonary tuberculosis.	—
F	32	Resp.	Haemoptysis due to chronic tuberculosis.	Found after P.M.
F	48	Resp.	1.(a) Pulmonary tuberculosis. 2 Epilepsy.	—
M	55	Non- Resp.	1.(a) Cardiac failure and Toxaemia. (b) Tuberculosis renal tract.	—
M	76	Resp.	Haemorrhage due to pulmonary tuberculosis and the industrial disease of pneumoconiosis.	Condition only found at post-mortem.
M	28	Resp.	1.(a) Broncho-pneumonia. (b) Pulmonary tuberculosis.	Said by general practitioner to have been notified but no record traced.
M	55	Resp.	1. Acute and chronic fibroid phthisis. 2. Pulmonary fibrosis.	A displaced person with no fixed residence. His condition was not discovered until after post-mortem examination.
M	33	Resp.	1 (a) Pulmonary tuberculosis.	Not notified to this authority. He had been notified elsewhere in 1945 and it is assumed that he had been discharged as cured.

II. Information Obtained from Registrar General's Transferable Deaths.

Sex	Patient		Cause of Death.	Remarks.
	Age	Resp. or Non-Resp.		
F	45	Non-Resp.	1(a) Generalised tuberculosis.	Not suspected during life. Diagnosed at post-mortem.
F	45	Non-Resp.	1.(a) Broncho-pneumonia. (b) Hypopituitarism. (c) ? tuberculoma. 2. Tuberculous Mesenteric adenitis. Post Mortem.	Discovered on post-mortem.
M	44	Resp.	1.(a) Tuberculous bronchial pneumonia.	Transfer from another Authority, described as of no occupation. Death took place at a private residence. Inferred that presence of T.B. not known before death.
F	77	Resp.	1.(a) Heart failure. (b) Pulmonary tuberculosis.	Ascertained by autopsy.
M	64	Resp.	Tuberculosis of lungs.	Diagnosed at P.M.
M	63	Non-Resp.	1. Pulm. Embolism due to thrombosis of pelvic vein. 2(a) Tuberculosis of spine. 2(b) Diabetes mellitus.	Diagnosed at P.M.
F	2	Non-Resp.	Tuberculous Meningitis.	Acute terminal infection. Diagnosed on P.M.
M	78	Resp.	Pulmonary tuberculosis and pneumoconiosis.	Unsuspected until P.M.
M	67	Resp.	1. Acute tuberculous broncho-pneumonia. Myocardialischaemia. 2. Partial gastrectomy for haematemesis and melaena from duodenal ulcer.	Acute terminal condition. Diagnosed P.M.
M	71	Resp.	1.(a) Pulmonary tuberculosis.	There was some doubt about the diagnosis of this case until a month before death when he was operated upon in hospital and then admitted to sanatorium. The Chest Physician overlooked the need for a notification during this period.

III. Information Obtained from Posthumous Notifications.

M	3	Non-Resp.	Tuberculous meningitis.	Diagnosis after post-mortem.
M	24	Resp.	Tuberculous meningitis. Miliary tuberculosis.	Diagnosis made at post-mortem.
M	61	Resp.	1.(a) Cachexia. (b) Pulmonary tuberculosis. 2. Influenza, bronchitis and emphysema.	Not diagnosed until death.
M	70	Resp.	Chronic pulmonary tuberculosis.	Found at post-mortem.
M	56	Resp.	Pulmonary tuberculosis. Silicosis.	Found at post-mortem.
M	49	Resp.	Toxaemia and heart failure, the result of silicosis, miliary tuberculosis and tuberculous broncho-pneumonia.	Diagnosis not made until after post-mortem examination.
M	58	Resp.	1.(a) Pulmonary tuberculosis.	Admitted to mental hospital under Lunacy Certificate, when there was no information that he suffered from any organic condition. Physical examination revealed positive pulmonary signs. By the time the X-ray and laboratory findings had been confirmed, his condition was extremely feeble and the following day he died. Notification of tuberculosis and death certificate returned on same day.
M	36	Resp.	1.(a) Pulmonary tuberculosis.	Admitted to mental hospital under Lunacy Certificate. Mass Radiography Unit showed suspicious opacities and it was recommended that he be kept under observation and subjected to further examinations which was done. In the three months preceding death, gradually lost flesh and strength but examinations were complicated and difficult due to maniacal state of mental health. A few days before death he collapsed and thereafter signs and symptoms of pulmonary tuberculosis were evident. The blood-stained spit returned positive findings on the day before his death. Notification of tuberculosis and certificate of death returned on the same day.
M	35	Resp.	1.(a) Pulmonary tuberculosis.	Patient admitted to mental hospital on statutory transfer. On admission was suffering from pulmonary tuberculosis and the Medical Superintendent had been assured that the former hospital authorities had notified the case.
M	46	Resp.	Tuberculous broncho-pneumonia and the industrial disease of pneumoconiosis.	Condition found only at post-mortem.

After adjustment for removals, recoveries and deaths, the total number of notified cases of tuberculosis on our register at the end of the year was 10,779, an increase of 420 compared with the previous year. The following table summarises the revision of the registers in the respective divisional areas:—

Div. No.	Number of cases on register 1st January, 1955				Number of cases added to register				Number of cases removed from register				Number of cases remaining on register 31st December, 1955				Number of cases remaining on Register	
	Respiratory		Non-Resp.		Respiratory		Non-Resp.		Respiratory		Non-Resp.		Respiratory		Non-Resp.		Total	Per 1000 Pop'l'n
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
1	168	117	49	51	20	32	4	4	21	17	5	8	167	132	48	47	394	6.7
2	58	43	17	22	8	7	4	2	3	3	1	—	63	47	20	24	154	6.7
3	182	122	48	32	24	14	6	5	10	8	1	—	196	128	53	37	414	7.4
4	212	144	33	49	46	22	4	6	28	13	4	5	230	153	33	50	466	6.9
5	206	137	39	49	60	34	6	9	36	19	5	5	230	152	40	53	475	6.5
6	99	73	16	12	17	15	2	2	20	14	5	6	96	74	13	8	191	5.5
7	36	33	5	10	7	7	3	—	5	5	—	4	38	35	8	6	87	3.5
8	192	150	34	56	17	32	4	8	26	15	3	3	183	167	35	61	446	5.9
9	74	68	24	26	21	6	5	3	9	9	6	6	86	65	23	23	197	4.0
10	126	118	20	33	18	11	1	1	9	6	3	3	135	123	18	31	307	6.8
11	213	154	25	42	35	12	1	2	24	5	1	4	224	161	25	40	450	7.4
12	209	155	39	63	31	17	6	3	23	11	4	6	217	161	41	60	479	8.4
13	148	103	29	48	29	20	2	4	15	15	4	4	162	108	27	48	345	4.2
15	76	79	35	28	23	15	1	3	10	4	3	—	89	90	33	31	243	5.0
16	133	115	21	24	10	21	1	1	25	25	2	3	118	111	20	22	271	5.0
17	93	62	17	29	11	9	5	5	10	9	3	3	94	62	19	31	206	4.2
18	210	151	43	24	41	32	3	2	21	15	4	3	230	168	42	23	463	7.9
19	183	138	45	29	23	29	7	10	32	27	13	9	174	140	39	30	383	6.8
20	212	137	60	59	39	26	5	16	38	11	14	14	213	152	51	61	477	5.4
22	403	257	114	81	58	42	10	9	41	25	9	10	420	274	115	80	889	10.4
23	246	175	29	48	25	19	4	9	14	9	1	3	257	185	32	54	528	8.3
25	223	194	36	27	26	15	6	3	33	29	4	6	216	180	38	24	458	6.1
26	110	85	25	21	18	15	1	5	15	10	2	5	113	90	24	21	248	5.4
27	140	127	47	33	23	26	2	—	15	10	1	2	148	143	48	31	370	9.3
28	171	164	50	49	29	25	5	4	22	19	2	3	178	170	53	50	451	7.8
29	139	143	28	32	15	11	3	—	11	5	2	1	143	149	29	31	352	10.5
30	241	199	24	26	37	18	1	5	23	13	—	4	255	204	25	27	511	8.1
31	210	147	56	45	58	34	8	10	20	10	12	2	248	171	52	53	524	6.2
	4,713	3,590	1,008	1,048	769	566	110	131	559	361	114	122	4,923	3,795	1,004	1,057	10,779	6.7

Divisional Medical Officers have received 2,389 notifications (1,143 admissions and 1,246 discharges) relating to patients admitted to, or discharged from treatment in 75 hospitals as follows:—

INSTITUTION	Respiratory								Non-Respiratory							
	Admitted				Discharged				Admitted				Discharged			
	Adults		Children		Adults		Children		Adults		Children		Adults		Children	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Bierley Hall Hospital, Bradford	6	6	—	—	5	11	—	—	—	—	—	—	—	—	—	—
Bradford Royal Infirmary	1	15	—	1	1	8	1	1	—	—	1	—	—	—	2	—
Bradley Wood Sanatorium, Huddersfield	28	16	—	—	22	14	—	—	—	1	—	—	—	1	—	—
Commonside Sanatorium, Sheffield	—	5	—	—	—	6	—	—	—	—	—	—	—	—	—	—
Crimicar Lane Hospital, Sheffield	9	1	—	—	3	—	—	—	—	—	—	—	—	—	—	—
Crookhill Hall Hospital, Conisbrough	69	—	—	—	66	—	—	—	—	—	—	—	—	—	—	—
Davos-Platz, Switzerland	2	4	—	—	8	6	—	—	—	—	—	—	—	—	—	—
Doncaster Isolation Hospital and Sanatorium	20	18	1	—	16	16	1	—	1	—	—	—	1	—	—	—
Gateforth Sanatorium, Hambleton, nr. Selby	61	—	—	—	59	—	—	—	—	—	—	—	—	—	—	—
Huddersfield Royal Infirmary	—	1	—	—	2	2	1	—	1	—	—	2	2	1	—	2
Killingbeck Hospital, Leeds	47	39	2	1	61	40	1	—	—	1	—	—	—	1	—	—
King Edward VII Hospital, Rivelin Valley Road, Sheffield	—	—	—	—	—	1	—	—	3	7	2	6	5	3	5	3
Leeds Road Hospital, Bradford	1	16	—	—	1	23	—	—	—	—	—	—	—	—	—	—
Northowram Isolation Hospital, Halifax	17	9	—	—	27	1	—	—	—	—	—	—	—	—	—	—
Oakwood Hall Sanatorium, Moorgate, Rotherham	13	15	2	—	25	9	4	2	2	—	1	—	—	—	—	—
Pinderfields Hospital, Wakefield	5	6	1	—	5	2	1	1	1	3	1	—	1	—	1	—
Scotton Banks Hospital, Knaresborough	41	57	1	3	40	84	1	5	—	2	2	2	2	2	3	2
Seacroft Hospital, Leeds	8	2	13	6	15	1	9	6	1	—	3	—	—	1	—	—
Sheffield City General Hospital	2	4	—	—	6	5	—	—	—	1	1	—	—	—	—	—
Shelf Sanatorium, near Halifax	18	28	—	1	27	37	—	1	—	—	—	—	—	—	—	—
Snapethorpe Hospital, Wakefield	2	3	—	—	2	3	—	—	—	—	—	—	—	—	—	—
St. George's Hospital, Rothwell, nr. Leeds	—	11	—	—	—	10	—	—	—	—	—	—	—	—	—	—
The Hospital, Grassington, nr. Skipton	68	70	—	—	68	73	—	1	1	1	—	—	—	—	—	—
The Hospital, Middleton-in-Wharfedale, nr. Ilkley	83	53	9	19	94	62	17	28	3	7	4	3	6	9	9	2
Wath Wood Isolation Hospital	27	20	—	—	11	22	—	—	—	1	—	—	—	1	—	—
Whitley Grange Hospital, Dewsbury	8	10	—	—	10	7	—	—	—	—	—	—	—	—	—	—
Winter Street Hospital, Sheffield	3	5	—	—	5	6	1	1	1	—	—	—	1	—	—	—
*Miscellaneous	26	14	5	6	29	23	1	4	4	3	1	5	2	3	4	3
	565	428	34	37	608	472	38	50	18	27	16	18	20	22	24	12

* The miscellaneous cases were under treatment at Beckett Hospital, Barnsley; Bradford Children's Hospital; Castleford and Normanton District Hospital; Castle Hill Sanatorium, Cottingham; Children's Hospital, Stockton; Connaught Military Hospital, Hindhead, Surrey; County Hospital, Wakefield; Crossley Hospital, Kingswood, nr. Frodsham, Lancs.; Doncaster Gate Hospital, Rotherham; Doncaster Royal Infirmary; Fairfield Sanatorium, York; Fielden Hospital, Todmorden; Halifax General Hospital; Iscoyd Park Colony, Whitchurch, Shropshire; Kendray Hospital, Barnsley; Kilton Hospital, Worksop, Notts.; Leeds General Infirmary; Lodge Moor Hospital, Sheffield; Marguerite Hepton Memorial Orthopaedic Hospital, Thorp Arch; Milford Chest Hospital, Godalming; Mill Hill Isolation Hospital, Huddersfield; Montagu Hospital, Mexborough; Moorgate General Hospital, Rotherham; Moorview Hospital, Meltham; Nether Edge Hospital, Sheffield; Newstead Sanatorium, Fishpool, Mansfield; Oldham and District General Hospital; Oldham Royal Infirmary; Otley General Hospital; Papworth Hospital, Cambridge; Park Lee Hospital, Blackburn; Poole Sanatorium, Middlesbrough; Preston Hall Hospital, Maidstone, Kent; Raywell Sanatorium, Cottingham; Robert Jones and Agnes Hunt Orthopaedic Hospital, Oswestry; Sheffield Children's Hospital; Sheffield Royal Infirmary; Southampton Chest Hospital; Stanley Royd Hospital, Wakefield; Strinesdale Sanatorium, Oldham; St. James's Hospital, Leeds; St. Luke's Hospital, Bradford; Thistle Hill Hospital, Knaresborough; Thornsby Annexe, Sheffield; Walton Hospital, Chesterfield; Wharnccliffe Hospital, Wadsley, Sheffield; Wrightington Hospital, nr. Wigan; York City General Hospital.

PART III

DIVISIONAL ADMINISTRATION

Following the Education Act, 1944, and in anticipation of the coming into operation of the National Health Service Act, 1946, the Council accepted the need for divisional administration of the preventive medical services. It was decided that this should be made to link up the work of the County District Councils with that of the County Council to produce divisions where all the preventive medical services would be administered, as a whole, by one medical man or woman acting as Divisional Medical Officer for County Council work and as Medical Officer of Health for the constituent County Districts. All the County Districts, with the exception of Queensbury and Shelf U.D., agreed to the scheme proposed by the County Council under Section 111 of the Local Government Act, 1933.

Under the provisions of the National Health Service Act, 1946, the County Council, as a Local Health Authority, was charged with the duty of providing the undermentioned services:—

- | | |
|---|---|
| (a) Health Centres. | (g) Ambulance Services. * |
| (b) Care of Mothers and Young Children. | (h) Prevention of Illness, Care and After-Care. |
| (c) Midwifery. | (i) Domestic Help. |
| (d) Health Visiting. | (j) Mental Health. |
| (e) Home Nursing. | |
| (f) Vaccination and Immunisation. | |

* This service is excluded from the divisional scheme. See separate report by the County Ambulance Officer on Page 60.

The administration of the various functions set out above was delegated to the West Riding Health Committee.

Under the Education Act, 1944, Divisional Medical Officers act as Divisional School Medical Officers under the direction of the County Medical Officer of Health who is Principal School Medical Officer, and are responsible for the control, supervision and co-ordination of the School Health Services within their divisions. The Divisional Medical Officer is responsible for the supervision of all staff on the divisional establishment and for the day to day control and direction of the County services. In this he has available to him the advice of Senior Medical Officers and supervisory nursing staff operating from the Central Office on school health, midwifery, home nursing and health visiting.

The Divisional Scheme for the preventive medical services which, in effect, amplifies the original draft arrangements under Section 111 of the Local Government Act, 1933, for securing that every Medical Officer of Health subsequently appointed for a County District should be restricted by the terms of his appointment from engaging in private practice as a medical practitioner, has the additional advantage of the Divisional Medical Officer being able to obtain complete co-ordination of the health services (including School Health) of the County Council and the public health work of the District Councils. This arrangement enables the Divisional Medical Officer to exercise a comprehensive supervision of all aspects of the preventive medical and environmental health services.

Again, as in each division the Divisional Medical Officer has at his disposal the services of a certain number of Senior or Assistant County Medical Officers and School Medical Officers, it follows that in the event of need (e.g., a serious outbreak of infectious disease) in any particular district, the Divisional Medical Officer as Medical Officer of Health can have readily available to him such additional medical assistance as is necessary.

The success of the present Divisional Scheme depends upon team work and this in turn presupposes a knowledge of what can be achieved by it — a cognizance on the part of those concerned, in fostering co-operation with other parts of the National Health Services for the benefit of the community as a whole.

The West Riding system of divisionalisation of the Local Health Authority's services has undoubtedly facilitated liaison at local level by making it possible for officers of the Local Health Authority to meet and to work in close touch with their opposite numbers in the hospital and domiciliary services. The aim of the Local Health Authority is to strengthen this desirable liaison with advantage to the community.

In general it may be said that the various arrangements existing within the County are working well, but the degree of liaison and co-operation varies in different parts of the County and in regard to different services.

Every effort is made in all divisions to foster a spirit of goodwill and active co-operation with the family doctors who have acquired a great awareness of the assistance available to them and their patients through the medium of the Local Health Authority services. The problems associated with the welfare of the old, infirm, disabled and mental illness cases appear to have done much to bring this about. Undoubtedly, cordial relationships exist between family doctors and the Local Health Authority medical, nursing and administrative staffs, and every endeavour is made to keep general medical practitioners informed of the services available, and to promote mutual understanding.

In January, 1952, the County Council decided that, as and when the opportunity arose, the number of Health Divisions should be reduced after consultation with the County District Councils concerned. Up to the end of 1955, as a result of the resignations of three Divisional Medical Officers, agreement has been reached, after consultation with the constituent County District Councils, for the following amalgamations:—

<i>Div. No.</i>	<i>County District Councils</i>	<i>Population (Estimated Mid. 1955)</i>	<i>Effective Date</i>
13.	Horbury U. Wakefield R. Ossett B.	8,150 19,250 14,500	1st July, 1955.
14.	Morley B.	39,580	
20.	Kirkburton U. Denby Dale U. Colne Valley U. Meltham U. Holmfirth U.	17,340 9,590 21,570 5,170 18,700	1st October, 1953.
21.	Saddleworth U.	16,610	
24.	Cudworth U. Darton U. Royston U.	8,770 14,330 8,110	1st May, 1954.
25.	Darfield U. Dodworth U. Wombwell U. Worsbrough U.	6,480 4,200 18,950 14,440	

Each amalgamation has involved the merging of the two Divisional Health Offices into one with financial saving on medical and clerical staff salaries and office expenses and with increasing efficiency of the services. Another amalgamation was under consideration at the end of the year.

The table below gives details of the divisions, populations, acreage, names and addresses of the Divisional Medical Officers, and the names of the Senior and Assistant County Medical Officers and School Medical Officers at 31st December, 1955.

<i>Div. No.</i>	<i>County Districts</i>	<i>Population Estimated (Mid 1955)</i>	<i>Acreage</i>	<i>Divisional Medical Officer</i>	<i>Senior and Assistant County Medical Officers and School Medical Officers</i>	<i>Address of Divisional Health Office</i>
1	Barnoldswick U. Earby U. Silsden U. Skipton U. Skipton R.	10,670 5,210 5,400 13,080 24,140	2,764 3,519 7,101 4,211 146,071	M. Hunter.	R. R. Stoakley. C. Harris.	19a High Street, Skipton.
	Totals:	58,500	163,666			
2	Bowland R. Settle R. Sedbergh R.	4,910 14,160 3,800	83,327 152,087 52,674	D. P. Lambert.	N. M. E. Robertshaw.	County Police Station, Cragdale, Settle.
	Totals:	22,870	288,088			
3	Keighley B.	55,720	23,611	H. M. Holt.	B. M. Leakey. D. E. Gledhill.	* Divisional Health Office, 3 Bow Street, Keighley.
4	Baildon U. Bingley U. Denholme U. Shipley U.	10,420 21,790 2,600 32,470	2,831 11,418 2,536 2,183	J. Battersby	G. Buckle D. C. Wall.	* P.O. Box 24, Town Hall, Shipley.
	Totals:	67,280	18,968			
5	Aireborough U. Horsforth U. Pudsey B.	27,450 14,000 31,090	6,856 2,706 5,323	G. P. Holderness.	H. M. Mitchell. C. Taylor.	* Council Offices, The Green, Horsforth.
	Totals:	72,540	14,885			
6	Ilkley U. Otley U. Wharfedale R.	17,190 11,320 6,220	8,610 2,934 39,378	R. A. W. Procter.	M. A. Hillis	Boroughgate, Otley.
	Totals:	34,730	50,922			

* Senior Assistant County Medical Officer and School Medical Officer

<i>Div. No.</i>	<i>County Districts</i>	<i>Population Estimated (Mid 1955)</i>	<i>Acreage</i>	<i>Divisional Medical Officer</i>	<i>Senior and Assistant County Medical Officers and School Medical Officers</i>	<i>Address of Divisional Health Office</i>
7	Ripon City	10,030	1,812	N. V. Hepple.	P. A. G. M. Ashmore.	High Skellgate, Ripon.
	Ripon and Pateley Bridge R.	14,860	124,861			
	Totals:	24,890	126,673			
8	Harrogate B.	51,710	8,320	D. D. Payne.	M. Pullan. W. Turner.	Municipal Offices, Harrogate.
	Knaresborough U.	8,250	2,494			
	Nidderdale R.	15,610	75,009			
	Totals:	75,570	85,823			
9	Tadcaster R.	27,750	75,833	R. G. Smithson.	J. A. G. Graham.	Wetherby House, Wetherby.
	Wetherby R.	21,500	64,424			
	Totals:	49,250	140,257			
10	Goole B.	19,400	1,267	S. K. Appleton.	E. M. R. Bell-Syer. M. J. Lowe.	Centenary Chambers, Boothferry Rd., Goole.
	Goole R.	9,140	36,776			
	Selby U.	10,170	3,848			
	Selby R.	6,540	32,909			
	Totals:	45,250	74,800			
11	Castleford B.	41,900	4,394	J. M. Paterson.	J. E. Fahy. D. J. Anderson.	"Castledene", Pontefract Rd., Castleford.
	Normanton U.	18,660	3,066			
	Totals:	60,560	7,460			
12	Featherstone U.	14,180	4,424	J. F. Fraser.	G. M. Mayhall. J. C. White.	Baghill House, Walkergate, Pontefract.
	Knottingley U.	10,630	2,835			
	Pontefract B.	24,410	4,865			
	Osgoldcross R.	7,790	33,954			
	Totals:	57,010	46,078			
13	Horbury U.	8,150	1,280	F. G. E. Hill.	B. Briggs. I. Hargreaves. M. H. Witt.	* Health Department, Town Hall, Morley.
	Wakefield R.	19,250	21,335			
	Ossett B.	14,500	3,333			
	Morley B.	39,580	9,493			
	Totals:	81,480	35,441			
15	Batley B.	39,980	4,461	J. F. Caithness.	F. M. Cox. D. M. Fisher.	Medical Officer's Department, Market Place, Batley.
	Heckmondwike U.	8,580	696			
	Totals:	48,560	5,157			
16	Rothwell U.	24,780	10,698	A. L. Taylor.	R. M. Bowker. D. M. Summers.	Oulton Lane, Rothwell, Nr. Leeds.
	Garforth U.	13,170	4,020			
	Stanley U.	16,670	4,866			
	Totals:	54,620	19,584			
17	Mirfield U.	11,860	3,394	W. M. Douglas.	E. M. Whitehead. G. Cust.	Elm Bank, Bradford Road, Cleckheaton.
	Spenborough B.	36,680	8,251			
	Totals:	48,540	11,645			
18	Brighouse B.	30,360	7,873	F. Appleton.	R. D. Haigh E. Atkinson.	* Mill House, Huddersfield Rd., Brighouse.
	Queensbury and Shelf U.	8,920	2,795			
	Elland U.	18,960	5,946			
	Totals:	58,240	16,614			
19	Hebden Royd U.	9,950	7,084	J. Lyons.	N. E. Gordon A. Seelig.	* Abraham Ormerod Medical Centre, Todmorden.
	Hepton R.	4,070	21,758			
	Ripponden U.	5,180	13,289			
	Sowerby Bridge U.	18,430	5,763			
	Todmorden B.	18,520	12,789			
	Totals:	56,150	60,683			

* Senior Assistant County Medical Officer and School Medical Officer

<i>Div. No.</i>	<i>County Districts</i>	<i>Population Estimated (Mid 1955)</i>	<i>Acreage</i>	<i>Divisional Medical Officer</i>	<i>Senior and Assistant County Medical Officers and School Medical Officers</i>	<i>Address of Divisional Health Office</i>
20	Kirkburton U. Denby Dale U. Colne Valley U. Meltham U. Holmfirth U. Saddleworth U.	17,340 9,590 21,570 5,170 18,700 16,610	13,847 10,165 16,054 5,906 17,648 18,485	E. Ward.	K. M. C. Haigh. * W. P. B. Stonehouse. * B. R. Ellis. E. D. Shaw.	"Woodville", Scar Lane, Golcar, Nr. Huddersfield.
	Totals:	88,980	82,105			
22	Hoyland Nether U. Wortley R. Penistone U. Penistone R. Stocksbridge U.	15,770 45,500 6,550 7,320 10,290	1,998 48,698 5,593 29,003 4,630	J. M. Russell.	J. J. Smith. * S. Lindsay.	Mortomley Hall, High Green, Nr. Sheffield.
	Totals:	85,430	89,922			
23	Hemsworth U. Hemsworth R.	13,750 50,170	4,163 29,019	J. S. Walters.	E. E. Cromb. * J. Hayes.	Adiscombe House, Barnsley Road, Hemsworth.
	Totals:	63,920	33,182			
25	Cudworth U. Darton U. Royston U. Darfield U. Worsbrough U. Wombwell U. Dodworth U.	8,770 14,330 8,110 6,480 14,440 18,950 4,200	1,746 4,725 1,423 2,018 3,420 3,838 1,857	R. S. Hynd.	R. Barnes. * S. G. A. Henriques.	6 Victoria Road, Barnsley.
	Totals:	75,280	19,027			
26	Swinton U. Wath upon Dearne U. Rawmarsh U.	12,200 14,040 19,540	1,718 2,677 2,602	D. J. Cusiter.	M. R. Menzies.	Dunford House, Wath upon Dearne, Nr. Rotherham.
	Totals:	45,780	6,997			
27	Adwick le Street U. Bentley with Arksey U.	18,470 21,430	3,605 4,950	J. Ferguson.	A. Kropacz.	Council Offices, Adwick le St., Nr. Doncaster.
	Totals:	39,900	8,555			
28	Doncaster R. Tickhill U.	55,590 2,560	75,092 5,580	A. Penman.	M. T. Burton. C. M. Dornan.	County Council Divisional Offices, Station Road, Doncaster.
	Totals:	58,150	80,672			
29	Thorne R.	33,660	38,419	G. Higgins.	R. B. Laidlaw-Becker.	Council Offices, P.O. Box 4, Thorne.
30	Conisbrough U. Mexborough U. Dearne U.	17,330 18,870 26,620	1,593 1,452 3,888	Vacancy.	B. R. A. Demaine. * H. F. Lindsay.	Council Offices, Adwick Road, Mexborough.
	Totals:	62,820	6,933			
31	Maltby U. Rotherham R. Kiveton Park R.	13,300 53,020 18,300	4,788 28,734 20,070	J. M. Watt.	A. P. Gorrie. * M. J. Hallinan. J. Lodwick.	"Edenthorpe", Grove Road, Rotherham.
	Totals:	84,620	53,592			

* Senior Assistant County Medical Officer and School Medical Officer

The clerical staff allocated to each Divisional Health Office varies according to the size of the division, the type of population, the establishment of professional, technical and nursing staffs, and the general complexities of public health administration in the division. The transfer of the work relating to the distribution of welfare foods from the former Ministry of Food to the Local Health Authorities as from 1st June, 1954, resulted in an increase of 34 clerks in the Divisional Health Offices. The following table shows the present position and the gradings of the 261 clerks employed.

<i>Divisions with population of—</i>	<i>No. of Divs.</i>	<i>Senior Clerk APT. IV</i>	<i>APT. III</i>	<i>APT. II</i>	<i>Other Staff</i>		
					<i>Clerical</i>		<i>General Division</i>
					<i>Grade II</i>	<i>Grade I</i>	
75,000 and over	6	3	3	—	6	1	58
50,000 — 75,000	12	1	10	1	11	1	96
25,000 — 50,000	8	—	1	7	1	6	44
Under 25,000	2	—	—	—	2	—	9
Total authorised establishment.		4	14	8	20	8	207

The inset map illustrates the layout of the 28 Public Health Divisions and the County Districts contained therein. As in 1946, only the Urban District of Queensbury and Shelf remains outside the scheme.

A conference of Divisional Medical Officers is held at the Central Office each month throughout the year (except August). This meeting is a conference in the fullest sense of the word, and affords an opportunity for an interchange of views, so that a consensus of opinion may be obtained. It takes into consideration problems peculiar to some Divisions owing to the varying characteristics of the Administrative County. Unusual problems encountered may be submitted for the benefit of all Divisions, or an unusual outbreak of infectious disease may be reported and control measures discussed.

The agenda for each conference is usually a full one, and the items discussed during the year have included such widely different matters as the progress of the scheme for the B.C.G. vaccination of Mantoux negative 13-year-old school children; methods of co-operation with family doctors; the care of the premature child in the home; the methods of prevention of problem families; the development of the health visiting, midwifery and home nursing services; also matters affecting school medical inspections and ascertainment and placing of handicapped children; the problems associated with mental defectives; and the home help service. Policy regarding these matters is discussed during the various conferences.

In addition, purely administrative and non-medical matters such as the distribution of welfare foods, control of approved motor car mileage, establishment and re-grading of divisional clerical staffs are discussed from time to time.

On occasions, officers from other departments and from other organisations attend to give their observations on problems before the meeting. For example, officers of the Ministry of Agriculture, Fisheries and Food, and the Medical Research Council, have been present during the year.

From time to time, when matters of special importance are under consideration by the West Riding Health Committee, the Chairman of that Committee may attend the monthly conference to obtain the observations, suggestions and opinions of the conference.

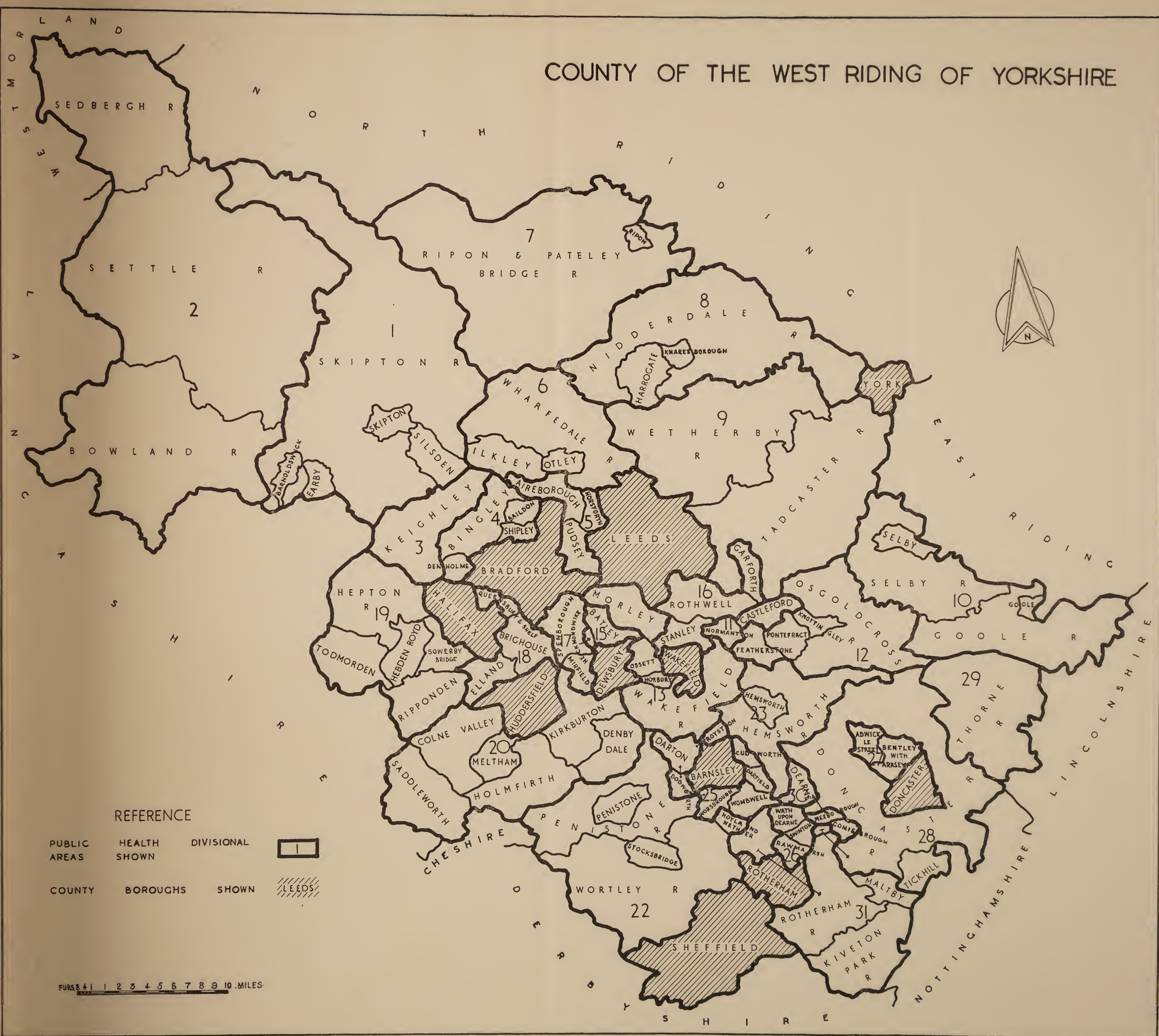
In order to expedite the business of the monthly conferences, matters of details affecting the issue of new divisional circulars, the introduction of new forms and the amendment or abolition of existing forms are referred to a sub-committee composed of a number of Divisional Medical Officers, together with the appropriate headquarters staff. The notes of their meetings are submitted to the monthly Divisional Medical Officers' conferences for approval. Experience has shown that this has greatly reduced the amount of time to be spent on minor matters of detail at the monthly conferences.

Lastly, a small Standing Sub-Committee has been formed (following a meeting at County Hall on 17th March, 1955) consisting of four general medical practitioners representing the West Riding Executive Council and four medical officers representing the medical staff of the County Council.

The Standing Sub-Committee has met on two occasions during 1955, and matters dealt with at these meetings included consideration of Circular 27/54 (Prevention of Break-up of Families), review of methods to increase vaccination against smallpox, and the provision of telephone facilities for Health Visitors and Tuberculosis Health Visitors.

This sub-committee has been most useful in fostering co-operation between the medical practitioners practising within the administrative area and the medical and nursing staff of the Local Health Authority. It provides a means of discussing problems common to both services and should be progressively useful in finding means of solving them.

COUNTY OF THE WEST RIDING OF YORKSHIRE



PART IV

NATIONAL HEALTH SERVICE ACTS

HEALTH CENTRES

“ 21.—(1) It shall be the duty of every local health authority to provide, equip and maintain to the satisfaction of the Minister, premises which shall be called ‘health centres’ ”

Once again I have to report that there has been no progress in the provision of Health Centres. The possibility of later addition to new multi-purpose clinics is always borne in mind when land for such purposes is purchased, and endeavours are made to secure sufficient land on such sites to enable extensions to take place in due course.

The erection of new multi-purpose clinics is all too infrequent due to the need for stringent economy and, as the same consideration applies to other building, it is improbable that, at the present time, permission to erect Health Centres would be given even if the need in particular areas could be established and suitable sites found.

CARE OF MOTHERS AND YOUNG CHILDREN

“ 22.—(1) It shall be the duty of every local health authority to make arrangements for the care, including in particular dental care, of expectant and nursing mothers and of children who have not attained the age of five years and are not attending primary schools maintained by a local education authority.”

Ante-natal Services

At the end of the year, there were 152 ante- and post-natal clinics in operation and 12,111 expectant mothers attended of whom 9,600 were new cases; the total number of visits made to the clinics was 60,203. By comparison with the previous year, there was a reduction in both the number of cases and attendances. This is no new trend, for attendances have been on the decrease each year in one part of the county or another since the inception of the National Health Service Act, nor is there any need for alarm, for with the setting up of a free maternity medical service and the provision of more lying-in beds in hospital, the expectant mother has been provided with a wider choice of service. However, the clinical aspect of ante-natal care cannot be divorced from the educative, and for this purpose, the services of the health visitor and/or midwife are essential in inculcating the principles of personal hygiene, dietetics and infant management. In the interest of the patient, therefore, it is imperative that the closest co-operation exists between all parties engaged in the service.

The following extracts on the service from reports of Divisional Medical Officers are interesting.

“The importance of ante-natal care is now generally realised. Liaison between the midwives and the clinic in domiciliary midwifery is good, and I should like to see institutional cases on a similar footing.”

“The attendances at medical officer sessions show little change from those of the previous year. There are marked variations, however, in the attendances between different districts, which are conditioned to a large extent by the variations in attitude of the medical practitioners towards local authority clinics, and by the extent to which they themselves are providing ante-natal care for their patients. There is a considerable demand for ante-natal relaxation classes both from patients and general practitioners, and the attendances at the classes continue to grow. The instruction imparted at these classes has been found of value, especially in the cases of primigravida, by helping the patient to approach her confinement with understanding and confidence, and by removing fear and anxiety, has contributed towards an easier and quicker labour.”

“The ante-natal clinic is an important centre for health education. Apart from routine ante-natal care, mothers are able to avail themselves of mothercraft instruction, relaxation and dental care. Relaxation classes appear to enable many mothers to have an easier time during labour; even if their value is only of a psychological nature, it seems to be proved by the number of expectant mothers who attend on the recommendation of previous attenders.”

Dr. MacWilliam, Obstetrical Officer at the Mexborough Montagu Hospital and Medical Officer of the County Council ante-natal clinics within Administrative Division No. 30, reports:—

“At the present time the improved results in obstetrics appear to be mainly due to more enlightened ante-natal and intra-natal supervision and to a general improvement in the health of the mothers, this latter being due to better conditions in the home and to improved nutrition. The expectant mother no longer waits until the last weeks of pregnancy before seeking medical advice but avails herself early of the facilities for ante-natal care. In the past, supervision during pregnancy was confined to the detection of toxæmia, disproportion and malpresentation. This has now been outdistanced, and in modern practice, the occasion is made an opportunity for raising the standard of health of the patient as a whole. Each expectant mother is encouraged to take up the free supply of Vitamins A and D and to buy the orange juice and a pint of milk daily at a greatly reduced price. At the County ante-natal clinics we supply routinely an iron preparation to correct the inadequate intake of iron in the diet. It is important to realise that a high haemoglobin level of the blood is equally necessary early in pregnancy as it is during labour and in lactation.

In recent years, great emphasis has been laid on the importance of nutrition during pregnancy and it is largely through our pre-natal clinics that the practical application of these nutritional principles can be taught. The instruction in diet and mothercraft is started at the patient's first visit to the clinic. There is evidence that the foundations of the nutrition of the infant are laid in pre-natal life and that the first three months of intrauterine life are specially important. We are, therefore, continuing to recommend a liberal mixed diet, rich in protein and vitamin content but low in carbohydrates. The necessity for painstaking advice is now greater than ever. During the war years, the system of priorities ensured for the expectant mother her full and proper share of the essential foods. She should now be advised how to buy, what to buy, and how to prepare the food bought.

The relief of pain in labour will continue to be in the forefront of our minds. The administration of analgesic drugs, even when supplemented by inhalational analgesia, is not now considered adequate. This is because an anxious and unhappy patient is as miserable during labour as she is apprehensive before it. Therefore, the emotional reactions of the patient to her labour must concern us. Although there are many different methods of inspiring confidence in the patient (teaching her to relax or instructing her in the anatomy of pregnancy and labour are examples at present in vogue), it is an essential part of one's duty to dispel her anxieties and fears by adopting a kind and sympathetic attitude to her problems. It has been shown that relaxation and anatomy classes are not able to achieve anything that the kindness and sympathy of the patient's attendants in the ante-natal clinic and during labour cannot do. It should be emphasised that an important contribution is made to the patient's peace of mind by the promise of her practitioner or midwife that he or she will be present at the time of her labour and remain with her during delivery."

Post-natal Services

There has never been a full realisation in the mind of the general public of the value of post-natal care and although much time has been devoted by medical officers in the clinics, and by midwives and health visitors, in endeavouring to educate mothers in the need for post-natal examination, apathy continues to exist. In one divisional area, it is estimated that only 25% of women who attended the ante-natal clinic continued to do so during the post-natal period.

Little statistical information on the incidence of maternal morbidity is available although at one time it was estimated that 10% of the women in England and Wales who bore children suffered from some degree of disability. It will be accepted that much of it would have been of minor character from which complete recovery would be made; on the other hand, the hazard of untold harm culminating in permanent ill-health must have occurred with frequency. That similar dangers exist to-day is all too apparent, and these hazards are for the most part the direct result of obstetrical injury occurring as a result of labour. It will be noted from the table on page 54, that of 1,739 medical aid notices issued by midwives during labour, 63% of them were in respect of some form or another of laceration of the birth canal, the majority of which was preventable.

No separate post-natal sessions were held during the year for the attendances at these clinics have declined since the advent of the medical practitioner services and do not justify autonomy. It is usual for the cases to be seen during ante-natal sessions at which 1,799 attendances were made by 1,546 women.

Dental Treatment of Expectant and Nursing Mothers

It is the duty of the local health authority to make arrangements for the dental care of expectant and nursing mothers and of children under school age. For this purpose, services of whole-time dental officers in the employ of the authority can be utilised in clinics, but where dental officers or clinics are not available, facilities can be provided by utilising private dental practitioners on a sessional basis.

The Chief Dental Officer reports:—

"With the opening of the additional clinics at Bingley, Maltby and Penistone, further patients have been taken over by County Dental Officers. This work is now being done at the following clinics:—

Aughton.	Goole.	Maltby.	Rothwell.
Barnoldswick.	Harrogate.	Morley.	Shipley.
Batley.	Heckmondwike.	Ossett.	Slaithwaite.
Bingley.	Honley.	Penistone.	Tadcaster.
Brighouse.	Ilkley.	Pontefract.	Thrybergh.
Castleford.	Keighley.	Pudsey.	Uppermill.
Cleckheaton.	Knaresborough.	Rawmarsh.	Wath.
Denaby.	Knottingley.	Rossington.	Wakefield.
		Ripon.	Wombwell.

This leaves the following areas where we have no clinic cover:—

Otley U.	Bowland R.	Queensbury and Shelf U.	Darton U.
Wharfedale R.	Sedburgh R.	Elland U.	Royston U.
Aireborough U.	Settle R.	Hebden Royd U.	Darfield U.
Scoby U.	Thorne R.	Hepton R.	Worsbrough U.
Selby R.	Stocksbridge U.	Ripponden U.	Dodworth U.
Horsforth U.	Wortley R.	Sowerby Bridge U.	Bentley U.
Skipton U.	Todmorden B.	Hoyland U.	Doncaster R.
Skipton R.	Kiveton Park R.	Cudworth U.	(except Rossington).
Silsden U.	Adwick U.		Kirkburton U.

In these districts we are permitted by the Ministry of Health to "farm out" the work to private dental practitioners. It is with great pleasure that I report that this scheme is working very smoothly with the closest possible co-operation and almost complete good will between all the parties concerned.

The following table indicates the work which has been carried out for expectant and nursing mothers by our own dental officers and private practitioners under the County Scheme.

	County Dental Officers					Private Practitioners	Total
No. of cases referred	1,921	1,323	3,244
No. of cases examined	1,625	963	2,588
No. found to require treatment	1,517	947	2,464
No. treated	1,234	529	1,763
No. made dentally fit	1,039	494	1,533
No. of extractions	9,641	5,134	14,775
No. of fillings	997	805	1,802
No. of general anaesthetics	1,204	361	1,565
No. of local anaesthetics	322	69	391
No. of scalings	264	233	497
No. of complete dentures	959	566	1,525
No. of partial dentures	355	221	576
No. of x-rays	13	22	35
No. of crowns	—	2	2
No. of inlays	3	4	7
No. of root treatments	3	2	5

In addition to the above, 70 cases made 137 attendances for treatment, etc., by dental hygienists.

It has still been impossible, owing to shortage of staff, to carry out any routine treatment for pre-school children and no separate records have been maintained of the number of these children provided with emergency treatment. The number of pre-school children being treated appears to be increasing and records are now being maintained and will be included in future reports."

Infant Welfare Centres

At the end of the year, there were 225 infant welfare clinics in operation at which 46,342 infants attended, making 390,859 visits. The breaking down of these figures indicates that approximately 68% of these attendances were made by infants under the age of one year. Whilst it can be assumed that from this group there will be a preponderance of young mothers who are probably receptive to the educational methods employed in the clinics, it cannot be overlooked that only a small proportion of children in the age group 2 to 5 years continues to attend the welfare centre, many of the mothers of whom would benefit from further guidance and education on the rearing of healthy children.

Dr Harvey, County Paediatrician, reporting on infant feeding, states,

"Most Mothers, both with their first and subsequent children, seem indifferent to any emotional or hygienic value in feeding their own offspring. Breast feeding is too often abandoned on flimsy excuses, such as colic, possetting, or loose stools due to an intercurrent common cold. The time may be due for re-appraisal of the risks and disadvantages of bottle feeding, as to whether a more diligent campaign for breast feeding should be adopted."

In the matter of artificial feeding, Dr. Harvey goes on to say that,

"Under-feeding is the chief hazard and we are finding that a full cream milk is well tolerated by most babies, even from the outset. It might help if we could abolish the euphemism of 'half-cream milk' and insist that such milk be described as half skimmed, so as to impress on mothers the inferior calorific value. There is a weird cult often employed by mothers in purchasing proprietary rusks and spending their energies crushing them with rolling pins to make milk feeds, when modern light flake cereal preparations will produce feeds of any desired consistency in a moment. A superstitious abhorrence of the use of egg-white still exists, possibly due to its being cooked to an india-rubber consistency, as a result of which the baby will spit it out. Soft scrambled whole egg and egg custard could well be a very early addition to milk diet."

One of the changing aspects in the functions of the Centre is in relation to mental health, and Dr. Lambert, Medical Officer of the Settle Division, has analysed 100 cases where the chief reason for consulting the clinic doctor was mental distress. In the majority of instances, the distress was related to the mother. The report goes on to say that in eighty-one of the cases the infants were under the age of one year, and in 59 of them, there was a simple anxiety state in the mother regarding her child's progress. A further 8 cases were that of a guilt complex in which each mother had shown unwillingness to feed her infant when it was within her power to do so. A further six anxiety states occurred in mothers by the re-assurance, without physical examination, that their infants were progressing favourably. One infant had to be admitted to a hospital 40 miles away for surgical treatment. The mother was unable to visit each day owing to the distance involved, and the child was difficult to manage on returning home three weeks later, due no doubt to parental separation. One mother was frankly neurotic and was referred through her family doctor for specialist advice. Of the 19 children over the age of one year, 14 of them were brought to the clinic because of enuresis. In four of these cases, there was marked neurosis in the mother for which the clinic could do no other than refer to the private doctor. The onset of enuresis in three instances was associated with the 'arrival' of another member to the family and coupled in one case with chosen undemonstrativeness on the part of the mother who honestly believed that this was the right way to behave towards a child. There were three cases where inconsistent management was the source of the trouble, two of them were also faced with the problems of a shared house. In two cases, the child was being over-indulged and over-protected, whilst in two other enuretics, the condition followed a separation from the mother on account of surgical emergencies. Of the cases where enuresis was not a symptom, anxiety following an attack of infectious disease accounted for three of them; a conflict of ideas between husband and wife regarding child management was responsible for another case. As a group, the mothers of the older children were more difficult to deal with; they attended the centre less frequently and less regularly, and their problems were of longer standing, and they usually needed to make greater mental adjustments.

The following extracts from reports of Divisional Medical Officers on this service are of interest.

"The time will come when we shall have to consider the reorientation of the siting of some of our clinics. The rehousing programme has been responsible for moving the population away from the clinic in certain districts, and we shall have to consider establishing clinics in closer proximity to the new housing estates."

"Attendances generally show little change from the previous year. Efforts to secure a better attendance of toddlers have been disappointing. The sale of dried milk and other foods in clinics, although of considerable convenience to mothers, is not perhaps so necessary in this as in a rural area, as many of the items are readily available at local shops."

"The focal point of the centres is gradually shifting from the weighing of babies to the giving of advice by doctors and health visitors, and an endeavour is made to carry out more health teaching. The minimum variety of food is stocked in the clinic, it being no longer considered necessary to supply cereals at the town clinics; mothers are advised on the simplest ways of preparing fresh vegetables for toddlers rather than being confronted by advertisements of the pre-cooked variety of which they are all too well aware."

"There has not been any depreciation in the popularity of the clinics, figures of attendances being generally higher this year. The clinic premises as a whole are not by any means ideal for the purpose, and the maintenance of such good attendances is a tribute to the staff. The rise in food sales at clinics, due to the addition of 'welfare foods,' is adding considerably to the work of the health visitor, particularly in those clinics where voluntary workers are not available."

"The sale of 'welfare foods' at the centres tends to increase congestion; on the other hand, it provides the health visitors with the opportunity of advising a mother on feeding problems and the necessity of immunisation of her infant."

New centres were opened at Cottingley, Staincliffe and Methley. At Loscoe the centre was discontinued, and that at Hellifield was replaced by the mobile unit. The first post-war clinic to be built in the County was officially opened at Morley on 17th October by County Alderman H. J. Bambridge, O.B.E., Chairman of the County Council.

Welfare Foods

The distribution of Welfare Foods has continued without any major difficulty during the first full year, and the following table shows the overall distribution during the year:—

	National Dried Milk (tins)	Cod Liver Oil (bottles)	Vitamin A and D Tablets (packets)	Orange Juice (bottles)
Issued to beneficiaries against coupons ...	517,379	160,908	59,580	812,877
Issued to Hospitals and Day Nurseries ...	1,009	648	—	5,037
	518,388	161,556	59,580	817,914

Comment was made by the Ministry of Health in a circular letter dated 19th August, 1955, to the falling off in consumption since 1st July, 1954, of all classes of Welfare Foods. The trend in the West Riding during 1955 is shown in the following table of the distribution during each quarter.

	National Dried Milk (Tins)	Cod Liver Oil (bottles)	Vitamin A & D Tablets (packets)	Orange Juice (bottles)
Jan. to March	133,213	43,028	13,952	169,973
April to June	128,088	35,635	14,534	194,802
July to September	130,129	36,701	15,738	256,773
Oct. to Dec	126,958	46,192	15,356	196,366

Illegitimate Children

In recognition of its responsibility under this section of the National Health Service Act, the County Council accepts a limited financial responsibility for the maintenance (in moral welfare homes of the expectant mother of an illegitimate child for the period of four weeks prior to the expected date of confinement and for the mother and her child subsequent to the lying-in period for a further four weeks' post-natal care. These periods are extended when necessitated on medical or socio-medical grounds. Under the scheme, 123 cases received ante-natal accommodation and 125 were in receipt of post-natal care.

There were 905 illegitimate live births and 667 of them were dealt with as requiring special assistance. The following summary indicates the manner in which the cases were disposed.

1. Number of cases dealt with during the year :							
(a)	Referred by Moral Welfare Organisations	...	...	...	...	...	70
(b)	Ascertained by staff of the Health Department	...	...	...	...	...	517
(c)	Referred by Other Services	...	...	...	...	...	80
Total							667
2. Analysis of cases :							
(a)	Married	(i)	with previous illegitimate children	...	...	...	93
		(ii)	without previous illegitimate children	...	...	...	113
(b)	Unmarried	(i)	with previous illegitimate children	...	...	...	120
		(ii)	without previous illegitimate children	...	...	...	320
(c)	Widowed	(i)	with previous illegitimate children	...	...	...	7
		(ii)	without previous illegitimate children	...	...	...	14
Total							667
3. Ages :							
(a)	Under 20 year of age	...	...	...	...	...	127
(b)	20-25 years of age	...	...	...	...	...	217
(c)	26-30 years of age	...	...	...	...	...	142
(d)	31-40 years of age	...	...	...	...	...	154
(e)	Over 40 years of age	...	...	...	...	...	27
Total							667
4. Disposal :							
(a)	Cases Settled	(i)	Marriage	...	...	...	30
		(ii)	Baby died	...	...	...	30
		(iii)	Grandparents taking baby	...	...	...	31
		(iv)	Baby adopted	...	...	...	75
		(v)	Baby fostered	...	...	...	7
		(vi)	Mother keeping baby	...	...	...	465
(b)	Cases referred elsewhere	...	...	...	...	...	11
(c)	Cases not finally settled	...	...	...	...	...	18
Total							667

There were 238 cases which did not come to the notice of Divisional Medical Officers. This figure would appear to be surprisingly large, but careful investigation has indicated that there is little prospect of any appreciable reduction, for many of the births take place outside the Administrative County, the infants being either adopted or boarded-out with foster parents without ever being actually domiciled in the County. A number of the cases occur under circumstances in which the mother and father are living in a state of unlicensed marriage.

In the interest of the child, where it is at all possible, the best place for it is with the mother, and it is interesting to note from the summary that this was the outcome of 69.5% of the cases. Assistance is also given in respect of some of the cases whereby day time nursery care is afforded the infant where the mother seeks employment in order to maintain the child and herself.

Premature Infants

Prematurity continues to be the chief cause of deaths under the age of one year and constitutes 58% of the deaths under one month.

All babies born of a birth weight of 5½ lb. or less are regarded as being premature. Whilst the clinical picture represented by the appearance and characteristics of a healthy premature infant vary with the foetal age at the time of birth, these characteristics become less distinctive as the period of gestation is lengthened, so that it often becomes impossible to differentiate between it and a full-term infant. Many of the premature babies, so designated by reason of birth weight, are really immature and frequently thrive much more successfully than an infant with a birthweight of 6 lb. or more. These infants are to be found in the 5lb. to 5½ lb. weight group on the statistical table which follows. From this table it will also be noted that of the 249 neo natal deaths, 229 died within the first week of life and of these, 131 did not survive the first day.

So far as the care of the premature infant is concerned, the part played by the nurse is of primary importance; she can do more towards survival than anyone. In the domiciliary field, she is also the midwife specially trained in this type of paediatrics, and therefore in the position of pre-determining a premature birth, notifying the family doctor and having all the necessary equipment at hand pending the arrival of the infant.

THE FATE OF PREMATURE BABIES BORN IN THE YEAR 1955, TO MOTHERS NORMALLY RESIDING IN THE WEST RIDING
ADMINISTRATIVE COUNTY AREA WHEREVER THE BIRTH TOOK PLACE

Total adjusted live births—24,601

Number of live premature births—1,766
Number born dead—324

Percentage of premature live births to total live
births—7.2

Weight Group lbs.	Number of Premature Births					Number Dying (Days of Survival)														Number surviving over 28 days					Percentage Survival 1955	Percentage survival in previous years							
	Born Alive					First Week							Second Week							Over 14 up to 28 days													
	A	B1	B2	C	Total	Born Dead	1	2	3	4	5	6	7	8	9	10	11	12	13	14													
																					A	B1	B2	C		Total							
5—5½	219	6	192	304	721	43	11	2	1	2	1	—	—	—	—	—	—	—	—	—	2	213	6	187	296	702	97.4	96.7	94.8	94.9	95.5	96.3	
4½—5	140	8	104	172	424	34	20	8	2	1	—	1	—	—	—	—	1	1	—	1	1	130	7	96	155	388	91.5	93.5	94.3	93.9	92.2	93.0	
4—4½	58	1	66	92	217	43	4	3	4	2	—	1	—	—	—	—	—	1	1	—	5	50	1	63	82	196	90.3	87.6	88.5	87.4	84.7	87.0	
3½—4	57	3	39	63	162	56	15	11	6	3	2	—	1	—	—	—	—	—	—	—	—	45	2	26	51	124	76.5	80.2	80.4	77.4	72.1	78.0	
3—3½	24	1	26	50	101	35	16	10	3	1	1	1	—	—	—	—	—	—	—	1	1	16	1	17	33	67	66.3	62.6	61.4	67.1	58.4	55.2	
2½—3	19	1	10	29	59	58	19	5	2	1	1	—	—	1	—	1	—	—	—	—	2	9	1	6	11	27	45.8	36.7	52.4	40.6	34.8	36.1	
2—2½	7	—	9	25	41	27	18	3	5	—	—	1	1	—	—	1	—	—	—	—	—	1	—	—	5	6	12	29.3	21.2	15.8	7.3	14.7	9.8
1½—2	7	—	3	14	24	17	13	6	—	1	1	1	1	—	—	—	—	—	—	—	—	—	—	—	1	—	4.2	7.5	12.9	6.1	2.8	5.9	
1½ and under	—	—	4	13	17	11	15	1	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	3.7	—	—	8.3	
Total	531	20	453	762	1,766	324	131	49	23	11	7	5	3	1	—	2	1	2	1	2	11	464	18	401	634	1,517	85.9	84.6	83.7	82.6	82.7	83.3	

229

9

249

A —Born in domiciliary practice.
B1—Born in a private nursing home.
B2—Born in a maternity home.
C —Born in a general hospital.

The weight groups in the first column of this table should be read as under:—
“5—5½lbs.” means “Over 5lbs. up to and including 5½lbs.”
“4½—5lbs.” means “Over 4½lbs. up to and including 5lbs.”
The remaining weight groups should be read in the same way, with the exception of the last group.

FOLLOW-UP OF PREMATURE BABIES BORN IN 1949 TO MOTHERS NORMALLY RESIDENT IN THE WEST RIDING ADMINISTRATIVE COUNTY AREA.

Total born	...	...	...	...	...	...	...	1,426
Number who have removed outside Administrative County or where parents refuse to co-operate in the inquiry	...	...	...	...	...	...	...	218
								1,208

Weight Group	Period of Survival					Survived over 6 years
	Number dying at following periods of life					
	Under 1 Year	1 year and under 2 years	2 years and under 3 years	3 years and under 4 years	4 years and under 6 years	
lb.						
5—5½	44	2	2	1	—	450
4½—5	33	2	—	1	—	230
4—4½	36	2	—	—	—	135
3½—4	38	—	—	—	—	69
3—3½	25	—	—	—	—	33
2½—3	34	—	—	—	—	14
2—2½	30	—	—	—	—	5
1½—2	15	—	—	—	—	—
1½ and under	7	—	—	—	—	—
Total	262	6	2	2	—	936
Percentage Survival.	78.3	77.8	77.6	77.5	77.5	77.5

The weight groups in the first column of the table should be read as under:—
“5—5½lbs.” means “Over 5 lbs. up to and including 5½ lbs.”
“4½—5 lbs.” means “Over 4½ lbs. up to and including 5 lbs.”
and so on, with the exception of the last group.

Day Nurseries

At the begining of the year there were 19 day nurseries in operation providing 825 places. In pursuance of the policy of the County Council that this service should be planned primarily from the point of view of the health service, and that unless there were strong factors to the contrary, the proper place for the mother of a young child was at home, the returns of attendances at the nurseries were under constant review. Special applications for the admission of children other than within the wide interpretation of ‘health grounds’ could only be considered by a special Sub-Committee set up for that purpose.

At the end of the year there were 7 day nurseries being maintained by the County Council, providing 310 places. These are sited as follows:—

Div. No.	Day Nursery	No. of Places Provided
3.	Keighley.	50.
4.	Shipley.	50.
8.	Harrogate.	40.
15.	Heckmondwike.	40.
18.	Brighouse.	40.
19.	Todmorden.	40.
19.	Sowerby Bridge.	50.

With the closure of day nurseries, the facilities for the training of student nursery nurses were seriously curtailed. The use of the hostel at Ilkley, which had for a number of years catered for those students resident in the County far removed from training facilities, was seriously affected, owing to the closure of those nurseries associated with it for training purposes. Provisional arrangements were made at other nurseries so that the students in residence could complete the course and the hostel was closed in September. This was one of the first local authority hostels of its kind to be utilised in connection with nursery training. It not only provided facilities for young girls to acquire the National Nursery Examining Board Certificate, who otherwise might not have been able to obtain the necessary training, but it made a useful contribution towards the stepping up of recruitment to general nursing by bridging the age gap between school leaving and admission to hospital for general training, a national problem still awaiting solution.

MIDWIFERY

" 23.—(2) It shall be the duty of every local health authority to secure, whether by making arrangements with Boards of Governors of teaching hospitals, Hospital Management Committees or voluntary organisations for the employment by those Boards, Committees or organisations of certified midwives or by themselves employing such midwives, that the number of certified midwives so employed who are available in the authority's area for attendance on women in their homes as midwives, or as maternity nurses during child-birth and from time to time there-after during a period not less than the lying-in period, is adequate for the needs of the area."

Under the Maternity and Child Welfare Act, 1918, (consolidated in the Public Health Act, 1936), a local supervising authority was given the power to aid the maternity service by the provision of refresher courses. It will be appreciated that there was no obligation upon the supervising authority to do so; however, the County Council approved its first instruction course in April, 1929, which was held at Bingley and attended by 113 midwives in residence with some 20 to 30 attending lectures daily. It was the first residential course of its kind to be held in the country. Similar courses were held in 1931 and 1934; they were of inestimable value by bringing midwives into contact with some of the most authoritative and inspiring teachers of the day.

The Midwives Act, 1936, decreed that every local supervising authority should provide a domiciliary service of midwives and arrange or provide courses of instruction for all midwives practising within its area. Under the authority of, and in pursuance of the relevant section of this Act, the Central Midwives Board issued rules in 1938 requiring that every midwife who, in the year 1939, gave notice to the supervising authority of her intention to practice, should within twelve months of giving such notice, have attended a course of instruction unless within seven years previous to the notice, she had attended such a course or had qualified by state examination for entry to the Midwives Roll. The outbreak of hostilities saw the suspension of the refresher course as a statutory requirement. In 1950, however, the County Council re-introduced courses for midwives in their whole-time employ, and made available an annual sum of £1,000 for the purpose.

By authority of the Midwives Act, 1951, the Central Midwives Board issued new rules during the year under review, wherein refresher courses are to be re-introduced, so that as from the 31st December, 1957, every midwife who gives notice to the supervising authority of her intention to practice, shall within twelve months of giving such notice, attend a course of instruction approved by the Board, unless within five years immediately preceding the date of giving such notice, she has attended such a course, or qualified by state examination for entry to the Midwives Roll. Subsequently, every midwife in practice will be required to attend a refresher course at least once in every five years.

So far as the domiciliary midwives of the County Council are concerned, this new rule offers no problem for, through their foresight in the earlier re-introduction of the attendance at courses, the whole of the staff will have complied with the rule in 1958. However, the County Council as a local supervising authority having the responsibility of providing or arranging for the provision of courses of instruction for all practising midwives in their administrative area, decided to utilise the facilities offered by the Royal College of Midwives, augmented by a special course organised by the Kingston upon Hull C.B. Council, and accordingly notified the Regional Hospital Boards of Leeds and Sheffield and the midwives in private practice of this intention, advising them to accept similar facilities indicating courses which are to be available during 1956.

During the year, the Central Midwives Board made adjustments to the regulations for the training of pupil midwives, one of the most important being that of including in the syllabus, the training in the teaching of mothercraft, infant care and nutrition. Few will deny that this work can rightly be regarded as coming within the province of the duties of the midwife, for in whom can the mother have greater confidence than the midwife in attendance at her confinement, and from whom would the teaching in infant management be more acceptable? For those midwives already qualified and in practice, there will be available within the refresher courses to be provided, tuition in these subjects.

Institutional Midwifery

Institutional versus domiciliary confinement continues to be a subject as controversial as ever, and the following comments of some Divisional Medical Officers are of interest.

" As a matter of economics, all midwifery should be carried out in a properly equipped institution; there is also the additional cover of clinical safety, but the ' liberty of the subject ' demands provision for domiciliary midwifery. All we can do is to encourage the trend towards institutional midwifery."

" It is evident that the present trend in this division towards institutional confinement continues. One of the main factors for this situation is the ready availability of beds in maternity units serving this area."

" It is regrettable that the vast majority of deliveries (82% of total live and still births) take place in hospital and most of the bookings are made there and not at the clinic where it would be possible, with available knowledge, to be more selective in allocating beds, and ensure that the beds were occupied by those whose needs were greatest, socially and obstetrically. This measure would relieve some of the pressure on beds and prevent the current necessity to discharge mothers and babies in the early days of the puerperium. At present, however, many doctors accede to the request of patients and send them direct to the hospital clinic with a note asking for a bed and the hospital staff feel in duty bound to grant these requests in the order in which the patients present themselves."

In respect of suspected or determined abnormality, the hospital is the only place for such an event. However, with the general improvement in social and environment conditions, it might have been thought that the potentially normal case would show preference for the domiciliary service. Over the county as a whole, the percentage of hospital births was similar to that of last year, namely 58, although in the county area within the administrative responsibility of the Leeds Regional Hospital Board, 66% of the total births took place in hospital as compared with 45% in the county area of the Sheffield Regional Hospital Board.

Division No.	Area	Total Births (Live & Still)	Percent- age of Hospital Births	Division No.	Area	Total Births (Live & Still)	Percent- age of Hospital Births
1	Skipton	630	82	15	Batley	488	79
2	Scettle	119	65	16	Rothwell	358	53
3	Keighley	919	78	17	Spenborough	527	80
4	Shipley	755	76	18	Brighouse	248	70
5	Horsforth	667	81	19	Todmorden	299	63
6	Otley	576	80	20	Colne Valley	472	70
7	Ripon	362	75	22	Wortley	1,053	60
8	Harrogate	1,194	82	23	Hemsworth	1,204	40
9	Wetherby	303	58	25	Barnsley	672	47
10	Goole	549	43	26	Wath	465	41
11	Castleford	801	58	27	Adwick le Street	526	37
12	Pontefract	519	50	28	Doncaster	675	43
13	Morley	1,129	63	29	Thorne	427	39
				30	Mexborough	1,048	38
				31	Rotherham	1,480	44
					Leeds Hospital Board Region	12,119	66
					Sheffield Hospital Board Region	6,346	45
					West Riding Administrative County	18,465	58

The length of time which the midwife should devote to the attendance on a woman following childbirth is known as the ‘lying-in period’ and is defined under the Rules of the Central Midwives Board as a period not less than fourteen days, or more than twenty-eight days after the termination of labour, during which the continued attendance of the midwife on the mother and child is requisite. The length of in-patient accommodation provided in hospital following labour, whilst primarily dependent upon clinical considerations, no longer follows the pre-war pattern of fourteen days’ ‘lying-in,’ although poor home conditions are frequently responsible for the retention in hospital of the mother and child for a longer period than would, in normal circumstances, be required. During the year there were 14,787 institutional births, 35% of which were discharged before the fourteenth day to the care of the domiciliary midwife or health visitor. It will be appreciated, therefore, that efficient care of the mother and child after early discharge from hospital is dependent upon the closest co-operation between the hospital, health authority and general practitioner.

Domiciliary Midwifery

Under the National Health Service Act, it is the responsibility of the local health authority to secure the provision of sufficient certified midwives to provide the domiciliary care of women during childbirth, whether they be acting as midwives or maternity nurses. Guidance of the midwife in matters related to her practice is given in a handbook incorporating the Rules of the Central Midwives Board. Every practising midwife within the administrative County must notify the Council, as the Local Supervising Authority under the Midwives Act, in January of each year of her intention to practice. She must notify the Authority when it has been necessary to call medical aid; in cases of death of the mother or child before the attendance of a doctor; in cases of stillbirth; when she has been in contact with conditions thought to be infectious, or is herself liable to be a source of infection; when it is proposed to substitute artificial for breast feeding and when she has assisted in the preparation of a body for burial.

Notices of intention to practice were received from 435 midwives of whom 269 were employed by the County Council, 140 by the Hospital Management Committees, and 26 in private practice. Of the 10,391 domiciliary births, 9,084 of them were attended by midwives acting in that capacity, and 1,307 as maternity nurses.

The latter figure also indicates the number of cases in which the general practitioner was present at the time of delivery.

A practising midwife must summon medical aid in all cases of illness or abnormality of the mother or child whether it is required during pregnancy, labour or the lying-in period. There were 3,024 of these notices issued of which the following is a summary.

PREGNANCY (474)									
Abdominal pain	12	Hydramnios	1	Toxaemias—					
Abortion—		Malpresentation	14	Albuminuria	11				
Complete	95	Miscarriage	21	Hypertension	3				
Threatened	80	Multiple pregnancy	2	Oedema	5				
Ante-Partum Haemorrhage	100	Post maturity	3	Blood pressure	10				
Breast condition	4	Pyelitis	2	Toxaemia	36				
General condition	66			Varicose veins	2				
Headache	3			Vomiting	4				

LABOUR (1,739)

Episiotomy	5	Obstructed	10	Vaginal	6
Foetal distress	41	Precipitate	4	Malpresentation	81
General condition	36	Premature	69	Multiple delivery	10
Haemorrhage—		Prolonged	231	Obstetric shock	4
Intra-Partum	6	Laceration—		Retained placenta	87
Placenta praevia	2	Labial	10	Still birth	17
Labour—		Perineal	1,080	Uterine inertia	40

LYING-IN (374)

Abdominal pain	2	Labial cyst	1	Recto-vaginal fistula	1
Blood specimen	3	Offensive lochia	2	Subinvolution	1
Breast condition	56	Phlebitis	38	Thrombosis	1
Chest condition	5	Post partum haemorrhage	86	Varicose veins	17
General condition	52	Puerperal pyrexia	14	Vomiting	3
Haemorrhoids	2	Pyelitis	1		
Headache	3	Pyrexia	86		

CHILD (437)

Abnormality	19	Eye condition	103	Prematurity	67
Asphyxia	19	General condition	78	Pyrexia	5
B.B.A.	9	Haematemesis	1	Skin condition	19
Chest condition	8	Jaundice	22	Snuffles	8
Cyanosis	28	Melaena	3	Thrush	2
Death	1	Pemphigus	1	Vomiting	9
Deformity	34	Phimosis	1		

The following statutory notifications were received from midwives during the year.

Maternal death	3
Death of the infant	91
Stillbirth	241
Laying out of the dead	35
Substitution of artificial feeding	1,879
Liability to be a source of infection	126

It is a requirement of the local supervising authority, under the Midwives Act, to exercise supervision of practising midwives within its area, and to enable this work to be executed effectively, it is delegated to Divisional Medical Officers who are assisted by two non-medical Supervisors. The work undertaken by the Supervisors is summarised as follows:—

Consultation with Divisional Medical Officers	126
Practical visits to midwives	246
General visits to midwives	205
Attendances at Labour	13
Attendances at parentcraft classes	49
Visits of inspection at maternity homes	22
Visits undertaken with pupil midwives	33

Post-Certificate Instruction.—Post-certificate courses organised by the Royal College of Midwives were attended by 57 midwives at the following centres:—Birmingham 6; Bristol 2; Brighton 6; Leeds 13; London 14; Newcastle 2; Oxford 6; Sheffield 8.

Analgesia.—For the purpose of the relief of pain during childbirth, gas and air analgesia and/or pethidine is available on request by the patient. Each midwife has been specially trained in this sphere and there are available 295 machines. The extent of demand for this service is indicated on a percentage basis for each of the administrative divisions in the following table:—

Division No.	Percentage receiving Analgesia			Division No.	Percentage receiving Analgesia		
	Gas and Air	Pethidine	Gas and Air with Pethidine		Gas and Air	Pethidine	Gas and Air with Pethidine
1	27	14	37	22	30	7	10
2	18	6	37	23	20	18	37
3	13	19	40	25	20	9	57
4	20	4	66	26	15	32	20
5	32	5	42	27	32	10	20
6	31	2	41	28	31	7	32
7	45	7	28	29	20	21	32
8	21	14	44	30	42	3	39
9	32	1	23	31	7	38	31
10	26	4	55				
11	72	1	14	Leeds Hospital Region	26	11	43
12	10	13	53	Sheffield Hospital Region	24	16	32
13	28	12	51	W.R. Administrative County	25	13	37
15	12	32	32				
16	17	29	34				
17	40	1	44				
18	27	6	57				
19	24	8	51				
20	19	13	45				

Flying Squad.—Arrangements are in operation from the under-mentioned hospitals whereby emergency units are available for the domiciliary treatment of patients whose condition is too grave to justify immediate transfer to hospital. This service has, over the years, made a valuable contribution towards the reduction of maternal mortality.

St. Helen Hospital, Barnsley.
St. Luke's Hospital, Bradford.
General Hospital, Halifax.
General Hospital, Harrogate.
Royal Infirmary, Huddersfield.

Maternity Hospital, Leeds.
Montagu Hospital, Mexborough.
Jessop Hospital, Sheffield.
General Hospital, Wakefield.

HEALTH VISITING

" 24.—(1) It shall be the duty of every local health authority to make provision in their area for the visiting of persons in their homes by visitors, to be called 'health visitors,' for the purpose of giving advice as to the care of young children, persons suffering from illness, and expectant or nursing mothers, and as to the measures necessary to prevent the spread of infection."

In a report covering a year which has been notable for the many articles in the 'press' on the contribution which has been made by the health visitor in the preventive health services, it is opportune to review the qualifications of this maid of all works and her manifold duties. The health visitor is a State Registered Nurse who must, in addition, possess the certificate of the first examination of the Central Midwives Board, and have successfully completed a course of special training for the Health Visitors' Certificate of the Royal Society of Health. For admission to the health visitors' training course, a careful selection of the applicants is essential to ensure that the candidates have the educational background and other qualities so necessary for the making of an effective socio-medical worker. In the West Riding, as with the majority of authorities in the country, the health visitor holds the dual appointment of health visitor and school nurse. Her many duties may be summarised briefly to include all aspects of school nursing under the School Health provisions of the Education Act, 1944; the visiting of persons in their homes for the purpose of giving advice as to the care of young children; persons suffering from illness and expectant or nursing mothers; and as to the measures necessary to prevent the spread of infection; the maintenance and management of the majority of the clinic services, details of her participation in this work can be readily seen in the appendix to this report; tuberculosis visiting where whole-time tuberculosis visitors are not employed; health education in the schools, homes and clinics; day to day supervision of the Home Help Service; close liaison with other workers and organisations concerned with matters of health and particularly with the general practitioner and hospital services. No less onerous are the demands for prompt and accurate clinical and statistical records; it cannot be wholly unexpected that her flair for accountancy is at times somewhat eccentric by the standards of whole-time trained accountants. So far as is practicable, efforts have been made and will continue to be made to relieve the health visiting staff of extraneous clerical duties and sales at clinics. A Working Party set up by the Minister of Health is at present reviewing the duties of a health visitor; it is not surprising that this review is taking a long time and the publication of its report, confidently expected during 1956, is awaited with interest.

Recruitment of health visitors has been disappointing; national advertisements for vacancies in the Dales, hitherto most popular, have lost their attraction; of the 24 new appointments during the year, 13 were from our own training scheme run in conjunction with the University of Leeds. These were sufficient only to replace the wastage due to resignation (18) and retirement (6). In this situation, it continues to be necessary to dilute the service by the employment of assistant health visitors, nurses who do not possess the Health Visitors' Certificate, who are able to relieve the qualified staff of their less exacting duties. At the end of the year, the staff consisted of 251 health visitors and 40 assistant health visitors. When due allowance is made for the whole-time school nurses (6) and tuberculosis visitors (14), it will be seen that there was then a deficiency of 30 in the authorised establishment of 341, inclusive of tuberculosis visitors.

The additional duties imposed by the National Health Service Act seemed overwhelming at the time, but have proved to have given excitement and adventure to the health visitor's work. They have now become part of her routine and the pattern which has evolved was subjected to little change during the year. There was a sustained effort to ensure that health visitors co-operated closely with the local general practitioners. In every area arrangements were made for the introduction of the health visitors to the family doctors by meetings and by correspondence; arrangements were also made for all health visitors to be on the telephone so that they could be contacted immediately by the practitioners. These efforts have shown a great improvement in relationship, more marked in some areas than others but particularly successful where the general practitioner is the local clinic doctor and where the health visitor is able to demonstrate her knowledge of social conditions and apply that knowledge when the need arises.

The visiting of mothers and young children remains the essential basis of the health visitor's work, but has become less demanding as a routine. This has allowed for better supervision of the unsatisfactory family, the problem family, and the more novel problems of the migrant family, largely a post-war phenomena, but very time consuming. The visiting of the aged has featured prominently in the work of the health visitors, largely arising from demands on the Home Help Service. It is work they find very satisfying, not least from the knowledge that the help which has been given enables the aged to retain their independence and to live a much happier life in their own homes.

There has been marked improvement on the education side of the work in the homes, the clinics and the schools, one result of which has been observed at the infant welfare centres where the demand for 'baby weighing' is becoming less marked, with a greater demand for advice. It is generally recognised that mothers who attend the clinics are those who appreciate the value of the health service and are less in need of advice than the minority who continue as absentees.

It is difficult to present a satisfactory statistical resume of the work of the health visiting staff. An increase in the number of visits is easily achieved at the expense of fewer and more worth while visits. Records of visits give no indication of the time consumed between successive cases in the more rural areas nor do records of clinic sessions show time spent in preparation or in subsequent visiting and clerical work arising directly from the clinic session. Nevertheless, such a summary is a useful index when interpreted in the light of these various factors and the opportunity is taken to give the following brief details of the work undertaken by the health visiting staff in their capacity as health visitors and school nurses during the past year.

No. of families or households visited during the year	...	...	...	...	91,153
No. of children under 5 years of age visited during the year	...	...	...	...	87,193
ANALYSIS OF VISITS.					
Expectant mothers	...	...	...	...	9,025
Children—under 1 year	...	165,378			
aged 1—2 years	...	86,388			
aged 2—5 years	...	117,011			
			...	...	368,777
Tuberculous households	...	...	...	...	8,465
Other cases	...	...	...	...	152,880
School health	...	...	...	...	30,502
Ineffective	...	...	...	...	53,158
				Total	622,807
CLINIC AND SCHOOL SESSIONS.					
Maternity and Child Welfare	...	...	...	...	25,485
Ultra-violet light	...	...	...	...	3,665
Parentcraft	...	...	...	...	614
Specialist—Chest	...	858			
Other	...	2,617			
			...	...	3,475
School Health	...	...	...	...	20,387
				Total	53,626

Refresher Training.—The County Council has long recognised the need to keep the health visiting staff aware of new developments and changing ideas by arranging for them to attend periodic refresher courses, and thus anticipated the Rushcliffe Committee's recommendation that such facilities should be afforded. At a time when the health visitor's duties were concerned only with mothers, infants and school children, it was possible to gather together the majority of the health visitors at a single course held, usually in August of each year, at the Bingley Training College where distinguished lecturers were invited, and where there were ideal opportunities for discussion and the interchange of ideas. The only criticism was that, with the exception of the lecturers, the interchange was between staff of the same authority and there was no infusion of practical experience of health visiting from other parts of the country. The changed conditions of the National Health Service Act brought a vastly increased staff and their widened responsibilities made a wholesale absence from the district impracticable. In this situation, the responsibility for refresher training has been approached in a variety of ways which together provide a solution to the problem more satisfactory than the former uniform and more administratively convenient method. A number is sent on residential refresher courses organised by authoritative organisations and approved by the Ministry of Health where, in addition to the content of the course, there are adequate opportunities for learning from experience gained in other parts of the country. Short courses are arranged at the County Council's Adult College at Grantley Hall, attended by distinguished lecturers and where the health visitors can exchange experiences with colleagues from other divisions. Group lectures are held where the health visitors from a group of conveniently sited divisions may attend to hear lectures on special subjects; these may also be attended by the midwives and home nurses, and provide further opportunities for co-operation and for a better understanding of their respective problems. Group discussions are held within the division and these again may also be attended by other public health nursing staff.

During the year, thirty-two health visitors attended special training courses arranged by the Royal College of Nursing or the Women Public Health Officers' Association at London (13), Leicester (3), Manchester (4) and Cambridge (12). Fifty-five health visitors attended a two-day refresher course held at Grantley Hall where Dr. Emrys Davies of the Central Council for Health Education dealt effectively with the subject "Teaching Methods for Health Education," the results of which, shown in health talks and poster designs contributed by the health visitors in attendance,

exceeded all expectations. Dr. J. C. MacWilliam, Joint Obstetrician in the service of the Sheffield Regional Hospital Board and the County Council, and Miss H. G. Cairney, Regional Adviser in Catering and Dietetics, Ministry of Health, lectured on "Nutrition for the Expectant Mother and the Family" to group meetings of health visitors, home nurses and midwives. This was the first attempt at combining the three branches of the public health nursing staff to learn from a lecture and discussion on a subject of common interest and the content of the discussions then and subsequently was an encouraging reward. At divisional group discussions, many attended also by the home nurses and midwives, the lessons of the training courses and lectures were discussed and there was a ready interchange of views on these subjects and on the many problems arising in their day to day work.

Supervisory Staff.—The two Superintendent Health Visitors have supervised the practical work of health visitors and school nurses and tuberculosis visitors. They spent much time in advising and guiding new entrants to the service, and also in promoting and encouraging group discussion and health teaching at infant welfare centres and schools. In all they paid 361 visits to health visitors and 219 visits to clinics. They also attended at divisional offices for appointment of staff, conferred with the Divisional Medical Officers and gave advice and guidance on the practical work of the health visitor. Work in connection with the after-care of premature babies discharged from the Leeds Maternity Hospital continued on a most satisfactory basis.

Student Health Visitors.—To meet the continuing shortage of qualified health visitors, the County Council, in conjunction with the University of Leeds, operates its own health visitors' training scheme and employs a health visitor tutor, Miss Edwards, who is wholly engaged on this work. It was envisaged that up to 40 students could be enrolled annually, but suitable candidates have not been forthcoming, and thirteen only were recruited from this source during the past year as compared with eighteen in 1954. For the period of the course, the student receives from the County Council, in addition to expenses and incidental fees, a training grant equal to 75% of the minimum salary of a qualified health visitor. Originally the grant approved was the equivalent of 50% of the minimum salary, but in the face of other competing authorities, this was raised initially to 60% and then to the present 75%. Competition is still evident and there are authorities who are now prepared to enrol students and to pay them the full salary of a qualified health visitor. This decision has no doubt been taken to meet the acute need for staff, but is to be deplored, and it is with pleasure, therefore, that one learns that representations are being made that the training grant or salary of student health visitors should be brought within the purview of the Nurses and Midwives Council of the Whitley Council for the Health Services.

The Health Visitor students sponsored by the West Riding Health Committee are accepted by the Medical Faculty at the University of Leeds. The course covers three academic terms. Lectures are given at the medical school by full-time members of the academic staff of the University and by part-time lecturers who work in the Public Health and Social Fields. Practical experience is very varied; it includes experience in the urban and rural areas of the West Riding and in the adjacent County Boroughs.

Fourteen students entered for the 1954/5 course. One of these withdrew for personal reasons, eleven passed the examination of the Royal Society of Health held at Leeds in July, 1955, and the remaining two re-entered for the examination in London in October and both were successful.

HOME NURSING

"25.—It shall be the duty of every local health authority to make provision in their area, whether by making arrangements with voluntary organisations for the employment by those organisations of nurses or by themselves employing nurses, for securing the attendance of nurses on persons who require nursing in their own homes."

The County Council's proposal to increase the establishment of Home Nurses from 228 to 290 was approved by the Minister of Health early in the year, and revised allocations to divisional areas permitted of the immediate employment of 274, leaving a reserve of 16 only to meet future developments. The incidence of retirements, resignations, sickness, training, etc., falls unevenly over the County area and causes repeated crises due to the absence of staff to cater for the work. The transfer of staff from neighbouring divisions is not a ready solution due to many of the nurses having strong local and domestic ties. To meet this recurring situation, therefore, it was intended that the first claim on the reserve strength of 16 should be the creation of a mobile reserve of nurses, specially recruited and strategically situated to be available to meet these emergencies and otherwise to be employed locally. The success of such a scheme can be measured only in the light of actual experience and as we have yet been unable to recruit the staff necessary in the divisions, it has not been possible to introduce this experiment.

The report of the Working Party on the Training of District Nurses was published in the latter half of the year. This recognised the general desire for a national standard of district training, and that the knowledge and experience of the Queen's Institute of District Nursing and Ranyard Nurses should not be lost to district training, but there was a divergence of view on the desirable length of time necessary for such training; the majority favouring a period of four months for nurses with state registration only, reduced to three months for those with additional qualifications, and the minority view expressed on behalf of the Ranyard Nurses and the Queen's Institute of District Nurses that the present periods of six and four months should not be materially affected. The

County Council is affiliated to the Queen's Institute of District Training, and continues to make use of the Institute's training facilities. It has authorised the enrolment of up to 40 students annually, either from new applicants or from existing staff who do not possess the District Training Certificate, and in this way, seeks not only to maintain and augment the home nursing staff, but also to ensure that the responsibilities attached to nursing in the homes are being discharged by nurses who have been fully trained in the work. Until this ideal can be achieved, it is essential to continue with the assistance of nurses with lesser qualifications who have the aptitude and desire to enter the service and whose work is closely supervised.

An award of the Whitley Council increases the annual holidays of nursing staff from four to five weeks, the effect of which is to reduce the overall working time by 290 weeks, the equivalent of more than 6 nurses. With a depleted staff containing a large ingredient of married women, many with children, one cannot spread the annual holidays evenly throughout the year, and particular staffing difficulties are anticipated next summer when temporary staff, additional to establishment, may be required to relieve the situation.

During the year, eighteen nurses completed approved courses of district training and seventeen others were under training at the end of the year. There was a wastage of 35 due to retirement (1), death (1), and resignation (33), and replacements were largely recruited through the training scheme, from married nurses who were free to work, and from nurses who, for various reasons, wished to return to their native county. The 287 staff doing home nursing consisted of 197 home nurses, 68 home nurse midwives, 9 village nurse midwives, and 13 state enrolled assistant nurses.

A high standard of nursing in the home has been maintained and there is now reason to suppose that the demand for home nursing has at last become stabilised, but for the unpredictable demands of epidemic illness. Injection therapy continues to consume a considerable portion of the home nurses' time, and to meet this demand, efforts have been made to establish injection centres where ambulant patients may attend upon the nurse; this solution is possible only in urban areas with adequate public transport. A summary of the nurses' work shows 846,404 visits to 39,663 cases during the year, an increase of 24,398 visits, although there were 629 fewer cases than in 1954. There has been no dramatic change in the case load but if the index for the 604,154 visits in 1949 is taken as 100, that for the subsequent years has been 111, 119, 123, 125, 136 and for the past year 140. Again, it is observed that the age group "Over 65" represents 42 per cent of the cases and 58 per cent of the visits (45 and 57 in 1954) whilst the group with more than 24 visits during the year represents 13 per cent of the cases and 41 per cent of the visits (14 and 44), thus confirming the impression that the greatest demands on the service are from the aged and chronic sick. The following details give a brief summary and analysis of the work.

<i>Type of Case Attended</i>									<i>No. of cases attended</i>	<i>No. of visits by Home Nurses</i>
Medical	...	...	...	...	...	...	...	...	28,338	641,981
Surgical	...	...	...	...	...	...	...	...	10,199	172,560
Infectious Diseases	...	...	...	...	...	...	...	...	109	1,068
Tuberculosis	...	...	...	...	...	...	...	...	736	28,053
Maternal Complications	...	...	...	...	...	...	...	...	281	2,742
TOTAL	...	...	...	...	...	...	...	...	39,663	846,404

<i>Age Groups</i>									<i>No. of cases attended</i>	<i>No. of visits by Home Nurses</i>
0-5	...	...	...	...	...	...	...	...	2,700	20,168
5-65	...	...	...	...	...	...	...	...	20,378	333,105
Over 65	...	...	...	...	...	...	...	...	16,585	493,131
TOTAL	...	...	...	...	...	...	...	...	39,663	846,404

Patients included above who have had more than 24 visits during the year	5,350	346,228
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A more detailed analysis shows that 274,978 or 32 per cent of the total visits by the home nurses were to cases requiring injections only. It would be purposeless to attempt any detailed classification of the wide range of preparations now included in domestic injection therapy but an effort has been made to reduce it to a few general headings. This reveals that 35 per cent of the injections were anti-biotics and involved an average of 11 visits per case, 23 per cent were insulin injections (72 visits per case), 19 per cent were injections for anaemia (15 visits per case), 3 per cent were for the injection of sedatives (31 visits per case), and the remaining 20 per cent (24 visits per case) were for a general miscellany of conditions. It is interesting also to find that the preponderance of injection therapy is undertaken by the home nurses in the more densely populated and industrialised southern part of the county area.

In 4 divisions it is recorded that the home nurses made 292 visits to 12 patients resident in aged person's homes, whilst the return of 145 patients making 155 visits to the home of the nurse suggests that this once common method of conserving the nurse's time and energy has lost whatever popularity it once possessed.

In one division, the home nurse attends the surgery of a busy general practitioner in a mining area to assist with dressings, injections and other minor treatment—a practice which has continued from the days when the District Nursing Association was largely financed from the local colliery. From 355 sessions at the surgery, the nurse undertook 4,524 ‘visits’ to 1,000 patients and her work included injections only (600), surgical dressings and injections (200), surgical dressing only (100), and other minor treatment, including ear syringing (100). In one other division only, some little help in the practitioner’s surgery is indicated by 16 ‘visits’ to 12 patients.

Practical supervision has been continued by the two Supervisors who paid 325 routine and 135 special visits to nurses. They had frequent consultation with Divisional Medical Officers on the appointment of staff and to discuss matters affecting the local services; they also attended nine group meetings of Home Nurses.

Refresher Training.—A profitable week was spent at the County Council’s Adult College, Grantley Hall, by 45 home nurses. The main theme of the course was “Preventive Medicine,” with special emphasis on the disabilities caused by Rheumatism, Arthritis and Tuberculosis. Disabilities of the aged and means for their early prevention were discussed by Dr. H. Droller, Consultant Geriatrician, St. James’s Hospital, Leeds. A demonstration of gadgets as now used in hospital was given by Miss Lyttleton, Chief Physiotherapist, Leeds General Infirmary. Nursing technique was demonstrated by Miss Corcoran, Matron of the Queen’s Training Home, Leeds.

Housing.—It is axiomatic that the home nurse and midwife should be resident within their respective nursing areas. This self-evident need became a major problem with the midwifery staff during the war and immediate post-war years, and was largely solved by the generous co-operation of the local district councils who made council houses available for that purpose. The major impact of housing, however, occurred with the transfer of the District Nursing Service to the County Council in 1948. It was the policy of the former District Nursing Associations to provide housing accommodation for their nurses, and in addition to rented houses, they possessed a number of houses of varying sizes and desirability. The County Council became the owner of these properties by purchase, and the tenant of the rented houses. Many of the houses were furnished and domestic help was provided in some of the larger properties. Two of the homes operated as training centres and were under the direction of Superintendents; however, the ensuing years saw many changes. The two training homes were closed and the premises converted into self-contained flats; some unsatisfactory houses have been disposed of; repairs, improvements and decorations have been carried out and furnishings have either been withdrawn or otherwise have been improved and replaced. Where accommodation in County-owned property has become surplus to home nursing requirements, it has been made available to the midwifery and health visiting staff. Additional self-contained flats have been provided in the adaptation of premises for clinic purposes at Swinefleet, Snaith and Heckmondwike, and similar provision is being made at Hightown, Castleford.

VACCINATION AND IMMUNISATION

“ 26.—(1) Every local health authority shall make arrangements with medical practitioners for the vaccination of persons in the area of the authority against smallpox, and the immunisation of such persons against diphtheria.

(2) Any local health authority may with the approval of the Minister, and if directed by the Minister shall, make similar arrangements for vaccination or immunisation against any other disease.”

Under Section 26, the Authority have approved schemes for vaccination against smallpox, immunisation against diphtheria, and immunisation against whooping cough.

Towards the end of the year approval was given by the Ministry of Health to the inclusion of the following additional paragraph in the Authority’s proposals:—

“The Council proposes also to make arrangements for offering to persons in its area, or to any groups of such persons, immunisation against any other disease in respect of which authority is sought from and given by the Minister of Health. The Medical Officer of Health will be responsible for keeping records directed towards assessing the value of any such form of immunisation.”

The inclusion of this clause has the advantage in that any of the Authority’s schemes for immunisation against other diseases, for example, vaccination against poliomyelitis, can be implemented immediately, subject to formal approval by the Minister, whereas until now there has been a waiting period of two months as required by Section 20 of the National Health Service Act, 1946.

Details of the work done during the year under the existing schemes for vaccination against smallpox and immunisation against diphtheria and whooping cough will be found in Part II of the Report under the heading of Epidemiology.

AMBULANCE SERVICES

" 27.—(1) It shall be the duty of every local health authority to make provision for securing that ambulances and other means of transport are available, where necessary, for the conveyance of persons suffering from illness or mental defectiveness or expectant or nursing mothers from places in their area to places in or outside their area."

The Service is under the charge of Mr. V. Whitaker, O.B.E., County Ambulance Officer, who has supplied the following report:—

					Year ended 31st Dec.		Variation on 1954	
					1954	1955	Increase	Decrease
Admissions	...	...	...	...	39,795	40,572	777	
Discharges	...	...	...	...	29,991	29,555		436
Transfers	...	...	...	...	8,442	9,103	661	
Out-Patients	...	...	...	...	330,666	347,573	16,907	
Accident Patients	...	...	...	...	10,485	12,205	1,720	
Children to Occupation Centres	...	...	...	...	398	965	567	
Total of Direct Service	...	...	...	...	419,777	439,973	20,196	
Total of Direct Service, Agency and Car Pool Services	...	...	...	...	449,272	470,395	21,123	
Total Mileage	...	...	...	...	3,207,046	3,299,971	92,925	

The increase in the number of ambulance users during the year under review is much less than for previous similar periods. It has, however, been possible to accommodate these additional patients without enlarging the vehicle fleet or increasing the staff establishment, by further development of the practice of controlling vehicle movement by radio.

An additional permanent transmitting station has been established at Goole, where in the very short period it has been in operation, a saving in the region of 60 miles per month has already been effected in respect of Goole depot vehicles only. It is anticipated that the mileage decrease will progress to a position similar to that obtaining in the Harrogate area where, in the twelve months following the setting up of their transmitter, the annual mileage was reduced by 8,449 miles. There has also been a marked decrease in the annual mileage run by radio equipped agency ambulances operated by the St. John Ambulance Brigade at Pateley Bridge and Ripon.

The principal item in the capital building programme is the Central Vehicle Maintenance Workshop, on which work is already in progress. The building will include new facilities for vehicle body repairs and repainting and is expected to be completed in 18 months.

Experiments over a two year period in connection with the introduction of Diesel engines in Ambulances have been satisfactorily concluded and the Health Committee is now satisfied that future vehicles for General Ambulance work should be powered by Diesel. This policy will lead to important savings in fuel costs and also to a lesser degree in engine maintenance costs.

Now the initial work of establishing the Service is completed, the work of the Administrative Headquarters is considerably stabilised. During the year under review, the Administrative duties have been subjected to an internal investigation which has produced a revision of office procedure. This, together with the addition of selected mechanical aids, has made possible a reduction of two staff in the Headquarters Clerical Establishment.

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

" 28.—(1) A local health authority may with the approval of the Minister, and to such extent as the Minister may direct shall, make arrangements for the purpose of the prevention of illness or mental defectiveness, or the after-care of such persons, but no such arrangements shall provide for the payment of money to such persons, except in so far as they may provide for the remuneration of such persons engaged in suitable work in accordance with the arrangements."

Tuberculosis

The efforts to eradicate tuberculosis continue with unabated vigour and still tread the time honoured path of early diagnosis, rapid treatment and effective rehabilitation, accompanied by contact tracing and improved environmental conditions, and aided by mass radiography, chemotherapy, and latterly by B.C.G. vaccination. The encouraging results of B.C.G. vaccination give hope to the possibility of this essentially preventive measure being extended to a much wider range of the population than is permitted under present regulations. Differences in the application of these traditional methods of approach are revealed in the reports of the Divisional Medical Officers from which the following items are extracted.

Dr. Hunter, Division 1 (Skipton), has arranged for the tuberculin testing of pre-school children at their "birthday" examinations at infant welfare centres.

Dr. Lambert, Division 2 (Settle), in co-operation with the local Chest Physician, undertook a special survey with a view to determining the source of infection in newly notified cases. He reports:—

“In 89 recent cases (71 pulmonary, 18 non-pulmonary) an average of 2.3 contacts was seen per case—excluding from the series two unusual cases where 20 and 22 contacts were seen. Of the pulmonary cases, 29 were infected outside the Division, 19 from cases in their own family, 2 at work, and 1 from a neighbour. In 20 cases the source of the infection was uncertain. Of these 20 cases 5 represent genuine inability to trace the source of the infection. In 15 cases the investigation was incomplete, because known family contacts refused to attend for inspection. Many of these were elderly men with chronic coughs. Of the 18 non-pulmonary cases 4 were infected elsewhere, 6 were probably milkborne infections, 3 were family infections, and in 5 the source was uncertain—four genuine, one due to refusal to co-operate in the investigation.”

Dr. Smithson, Division 9 (Wetherby) reports:—

“The arrangements whereby the Divisional Health Office relies on the Ministry of Agriculture and Fisheries Veterinary Department to investigate herds giving biological positive samples of milk works reasonably satisfactorily. Much of the work in this regard comes to notice as a result of routine testing of milk at the Pasturisation Plants dealing with the product of the Farming Industry in the Division before it is distributed to Urban Populations. The growth of attested herds is a welcome thing from the point of view of prevention of Tuberculosis.”

Dr. Appleton, Division 18 (Brighouse), reports that as a result of his policy of tuberculin testing children attending the ultra-violet light treatment clinic, a further case of tuberculosis was discovered during the year.

Dr. Lyons, Division 19 (Todmorden), submits a further interim report on the tuberculin survey of infants born in Sowerby Bridge 1953-4, a survey which will not be completed until September, 1956.

“Total live births Sowerby Bridge U.D. between October 1st, 1953, and September 30th,									
1954 ... ..	...	...	...	...	...	...	...	...	268
No. of infants whose parents consented to survey ... ..	...	...	...	...	...	...	...	...	223 (83.2%)
No. of infants whose parents refused survey ... ..	...	...	...	...	...	...	...	...	30 (11.2%)
No. of infants who have received (or are receiving) periodic tuberculin tests ... ..	...	...	...	...	...	...	...	...	213 (79.5%)
No. of infants eliminated from survey by reasons of removal from district ... ..	...	...	...	...	...	...	...	...	38 (14.2%)
No. of infants eliminated by reason of death ... ..	...	...	...	...	...	...	...	...	6 (2.2%)
No. of infants eliminated by reason of B.C.G. vaccination as contacts ... ..	...	...	...	...	...	...	...	...	5 (1.8%)
No. of positive reactors discovered before 1st January, 1956 ... ..	...	...	...	...	...	...	...	...	2 (0.7%)
Average age of infants in survey at January 1st, 1956 ... ..	...	...	...	...	...	...	...	...	21 months approx.
Number of tuberculin tests performed to date ... ..	...	...	...	...	...	...	...	...	1,150 approx.

The two infants shown to be positive reactors were investigated clinically by the Consultant Chest Physician and a search was made for the source of infection. In the case of the first infant there was no clinical evidence of disease and X-ray examination of family contacts also revealed negative results. The second infant was found to be a “primary complex” and was notified as suffering from tuberculosis. Investigation of the other members of the family revealed that the mother was suffering from active pulmonary disease with cavitation, and had a positive sputum. An elder brother of the infant was found to have a positive Mantoux, hilar adenitis and a small lesion in the right lung. The mother and her two children have been admitted to sanatorium and have to date made satisfactory progress.”

Dr. Ward, Division 20 (Colne Valley) reports:—

“In January, 1955, notification was received to the effect that a male teacher at a Secondary Modern School was suffering from pulmonary tuberculosis. After consultation with the Consultant Chest Physician and the Medical Officer in charge of the Bradford Mass Radiography Unit, it was agreed that X-ray examination should be offered to all the children and staff likely to have been contacts. Transport was arranged and 133 pupils and 11 staff attended for examination. Fortunately no cases of tuberculosis were found.”

Dr. Cusiter, Division 26 (Wath upon Dearne) reports:—

“In the case of a pupil at the local Grammar School who was diagnosed as suffering from miliary tuberculosis, 68 school contacts were X-rayed with the co-operation of the Sheffield Mass X-ray Unit. All were negative.”

Dr. Penman, Division 28 (Doncaster) reports:—

“One man, sputum positive, was advised by the Consultant Chest Physician to remain off his work as a saddler in a small factory. The tuberculosis visitor found he was still working, thereby exposing others to the infection. Arrangements could not be made for him to work ‘in isolation’ and as the extent of his disease at that time demanded rest, further representations were made to him, with the desired result.”

In four reports of Divisional Medical Officers, favourable mention is made of the increasing tendency to arrange special sessions at the local chest clinic for the examination of young children, so as to avoid their being in contact with adult cases who otherwise might be in attendance at the clinic.

A report on the tuberculin testing of school entrants in the Barnsley (No. 25) Division appears on pages 127 and 128 in the School Health Section of the Report.

B.C.G. Vaccination.—

(a) **CONTACTS.**—The 1,019 contacts successfully vaccinated during the year makes a total of 3,989 contacts who have been afforded this new protection since the scheme was introduced in 1950.

Year	Number vaccinated	Results of Vaccination		
		Successful	Unsuccessful	Not ascertained
1950	143	127	3	13
1951	697	667	9	21
1952	730	679	20	31
1953	681	613	8	60
1954	972	884	7	81
1955	1,099	1,019	13	67
TOTAL	4,322	3,989	60	273

When due allowance is made for the cases where the result of the vaccination was not finally ascertained due to removal, failure to attend the clinic, etc., it will be seen that there was a favourable result in 99% of the cases dealt with.

In the full knowledge that each one of these patients was in close contact with a known case of tuberculosis, it cannot be doubted that this preventive measure, undertaken by the Chest Physicians on behalf of the County Council, has been of incalculable value.

The one cause of concern which arises from time to time is the difficulty in arranging for the segregation of the infant contact for the desired period of 6 weeks after vaccination. In many cases, this does not arise when the tuberculous patient is in, or can be admitted to, hospital, when the child can be retained in hospital or maternity ward, or where it can be placed in the care of relatives. There remain the few for whom no such arrangements can be made and for whom it would be unwise to accept the risk of leaving them at home; in these cases it has been usual to make special representation for short-stay accommodation in residential children's nurseries and we are deeply indebted to the Children's Officer for his ready and sympathetic co-operation. Representations are made that accommodation provided in this way should be wholly financed by the County Council as a preventive measure and not be subject to contributions by parents who are often reluctant to be separated from the child, but this is a question of secondary importance to the need for segregation. The number of children falling to be dealt with in this way would not appear to be sufficiently large to warrant the setting up of a special hostel for segregation purposes.

Details of vaccinations undertaken during the year are given in the following table.

	AGE GROUPS													All Ages
	Under 1 year Months				Years									
	0—	1—	3—	6—	1—	2—	3—	4—	5—	10—	15—	20—		
Vaccinated:														
Male	55	36	43	39	48	45	48	40	119	52	16	3	544
Female	67	44	40	30	36	52	30	29	105	80	28	14	555
Total	122	80	83	69	84	97	78	69	224	132	44	17	1,099
Result of Vaccination														
Successful:														
Male	49	33	39	35	45	43	46	38	112	51	16	3	510
Female	62	42	36	26	34	47	28	27	96	73	26	12	509
Total	111	75	75	61	79	90	74	65	208	124	42	15	1,019
Unsuccessful	—	2	—	—	—	2	2	1	3	2	—	1	13
Not finally ascertained	11	3	8	8	5	5	2	3	13	6	2	1	67

(b) **SCHOOL CHILDREN.**—The extension of B.C.G. vaccination to thirteen-year old school children was approved in 1954, in which year vaccinations were commenced in five divisions. By the end of 1955, they were being undertaken in twenty-one divisions and will be extended to the remaining seven divisions as soon as staffing and other difficulties can be overcome. The greatest care is taken to investigate and record any untoward incidents which may arise in consequence of or concurrently with either the tuberculin testing or the vaccination. On tuberculin testing, Dr. Hynd, Division 25 (Barnsley), reports:—

“A varying time for children to react to tuberculin has been found. Some children show the maximum reaction within forty-eight hours while others have a delayed reaction up to six days. The majority, however, show the maximum reaction around seventy-two hours. Local reactions to Tuberculin were all within normal limits, save in one instance only. The child was referred to the Chest Physician, but no lesion was found in her chest nor in any member of the family.”

Following a series of vaccinations, Dr. Paterson, Division 11 (Castleford), reports that five girls developed a reaction within a few days of vaccination and all were x-rayed with negative results, whilst Dr. Payne, Division 8 (Harrogate), reports:

"A school girl received an injection of B.C.G. vaccine on the 6th May, 1955, her age then being 13 and 3 months. About two months after the injection, the papule broke down forming a shallow ulcer with undercut edges. The ulcer was circular in shape and about 8 m.m. in size. A few weeks later a further ulcer formed about a centimetre below the previous ulcer referred to, and separated from the previous ulcer by apparently healthy skin. The second ulcer was similar in size to the previous one and also had undercut edges with slight bluish tinge in the skin surrounding the ulcer. There was no axillary adenitis, and the ulcers were not particularly painful. By the 3rd October, 1955, both ulcers were giving serous discharge and were at their maximum size.

The case was shown to Dr. Henry at the Chest Clinic, who undertook many thousands of B.C.G. inoculations in Greece for the World Health Organisation; he had not seen any reaction similar to the case of this child.

A swab taken from this ulcer showed very scanty epithelial cells and leucocytes, culture showed scanty growth of *Staph. albus* and diphtheroid bacilli. No acid fast bacilli were seen, and a T.B. culture was negative.

On Dr. Henry's advice a sterile powder of Sodium p-Aminosalicylate was applied to the ulcers; the application was, however, painful and the condition did not appear to improve. A scab formed over the ulcers and gradually dried up during the months of January and February, 1956, and in March there was only a very small scab left on the lower ulcer.

It appears probable that this was a lupoid reaction which, although uncommon with B.C.G., does occur more commonly with Vole bacillus."

The following table summarises the work undertaken during the year.

1. ACCEPTANCES.

No. of 13-year-old children offered tuberculin testing and vaccination if necessary	...	...	...	...	...	...	...	...	...	13,838
No. found to have been vaccinated previously	...	...	...	...	...	...	...	...	...	37
No. of acceptances	...	...	...	...	...	...	...	...	...	9,895
Percentage of acceptances	...	...	...	...	...	...	...	...	...	71.7

2. PRE-VACCINATION TUBERCULIN TEST.

No. of children tested	...	...	...	...	...	...	...	...	...	9,606
Result of test:										
(i) Positive	...	...	...	...	...	...	...	...	3,038	
(ii) Negative	...	...	...	...	...	...	...	...	6,397	
(iii) Not ascertained	171	
									————	Total
										9,606
Percentage positive	32.2

3. VACCINATION.

No. vaccinated	6,344
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4. TUBERCULIN TEST TWELVE MONTHS AFTER VACCINATION.

No. tuberculin tested after 12 months	111
Result of test:										
(i) Positive	...	...	...	...	...	...	...	...	96	
(ii) Negative	...	...	...	...	...	...	...	...	15	
									————	Total
										111

In addition, records were received relating to 22 children normally resident in the county whose vaccination had been undertaken by arrangements made by neighbouring authorities.

The result of vaccination has been ascertained previously by a tuberculin test made six weeks after vaccination, and this has revealed 99+ per cent. successful. The Ministry of Health has suggested that the importance of this test is secondary to a similar test which should be taken 12 months after vaccination to ensure that the artificial immunity is maintained. The results of this test are shown in the table and although the numbers are small, they do reveal that 14 per cent. had reverted to negative after successful vaccination.

Mass Radiography.—Fifty-seven thousand two hundred and ninety-one persons from the Administrative County were examined by the mass radiography service (40,020 by units of the Leeds Regional Hospital Board and 17,271 by units of the Sheffield Regional Hospital Board). Ninety (0.16 per cent.) were found to be suffering from active tuberculosis, 338 (0.59 per cent.) had signs of inactive tuberculosis and in 1,032 (1.80 per cent.) other non-tuberculous abnormalities were discovered. An analysis of the latter conditions reveals the surprising total of 305 cases of pneumoconiosis, 261 from the predominantly mining and heavy industrial area of the Sheffield Region where they represent 43 per cent. of the non-tuberculous abnormalities and $1\frac{1}{2}$ per cent. of the total examined. Details are given in the following table.

A. LEEDS UNITS

Survey undertaken at	No. Examined	Abnormalities Discovered			
		Tuberculosis		Other	Total
		Active	Inactive		
Barnoldswick (public)	1,022	1	7	9	17
Barnoldswick (factory)	251	—	—	—	—
Eastburn	286	—	3	3	6
Earby	709	1	7	2	10
Silsden	831	2	4	7	13
Skipton	402	—	1	5	6
Victoria Park Child Welfare Centre, Keighley	1,355	—	10	17	27
Princess Hall Baths, Bingley	997	—	5	11	16
Saltaire Road C. S. School, Shipley ...	2,461	4	14	34	52
Salts Ltd., Shipley	866	6	10	11	27
Menston Hospital	2,392	17	37	41	95
Reuben Gaunt & Sons Ltd., Farsley ...	415	3	4	3	10
Pudsey	2,075	5	13	21	39
St. John Ambulance Hall, Ripon ...	1,219	—	6	7	13
Harrogate General Hospital and St. Mark's Parochial Hall, Harrogate	2,394	—	8	25	33
The Institute, Bramham	285	—	1	—	1
Secondary Modern School, Boston Spa	251	—	—	—	—
Goole	2,786	5	2	14	21
Castleford	1,310	2	5	16	23
Normanton	1,228	4	8	24	36
Croft House, Ossett	1,582	—	7	22	29
Multiple Clinic, Corporation Street, Morley	2,410	6	15	36	57
Batley	2,205	—	16	25	41
Mirfield	865	—	6	12	18
Robert Dempster & Sons Ltd., Elland	210	—	2	3	5
St. Paul's Church, Elland	1,930	7	16	17	40
Stansfield View Hospital, Todmorden	171	—	—	2	2
Mechanics' Institute, Uppermill ...	1,390	4	7	7	18
Civic Hall, Slaithwaite	1,427	1	9	5	15
Messrs. D. Brown (Tractors) Ltd., Meltham	1,629	2	4	14	20
Carlisle Institute, Meltham	548	1	2	5	8
Miners' Welfare Baths, Scissett ...	2,118	—	11	20	31
Total	40,020	71	240	418	729

B. SHEFFIELD UNITS

Hoyland	3,490	2	5	137	144
Loxley	285	—	1	6	7
Stannington	383	—	2	19	21
Royston	1,141	—	6	35	41
Parkgate Iron and Steel Co.	1,255	1	8	17	26
Baths Hall, Rawmarsh	1,637	1	7	51	59
General Electric Co., Swinton ...	1,011	1	12	15	28
Queen Street School, Swinton ...	507	1	6	24	31
Public Library, Tickhill	843	1	3	17	21
Barnburgh Main Colliery	1,254	1	12	51	64
Welfare Hall, Goldthorpe	1,432	—	12	69	81
St. Hilda's Hall, Thurnscoe	2,135	3	21	129	153
Church Hall, Swallownest	737	3	2	22	27
Middleton Institute, Dinnington ...	1,161	5	1	22	28
Total	17,271	19	98	614	731
Total for the County Area	57,291	90	338	1,032	1,460

The non-tuberculous abnormalities are classified as follows:—

	Leeds.	Sheffield.
1. Abnormalities of the bony thorax and soft tissues—congenital ...	31	3
2. Abnormalities of the bony thorax and soft tissues—acquired ...	12	2
3. Tumours of the bony thorax: primary and secondary ...	1	—
4. Congenital malformation of the lungs	7	—
5. Bacterial and virus infection of the lungs	13	19
6. Other infections of the lungs	5	—
7. Bronchiectasis	60	26
8. Honeycomb lung	1	—
9. Emphysema	22	30
10. Pulmonary fibrosis—non-tuberculous	40	47
11. Pneumoconiosis	44	261
12. Spontaneous pneumothorax	1	—
13. Benign tumours of the lungs and mediastinum	10	7
14. Carcinoma of the lung and mediastinum	10	9
15. Metastases in the lung and mediastinum	—	1

Non tuberculous abnormalities (*continued*).

	Leeds	Sheffield
16. Enlarged mediastinal and bronchial glands—non-tuberculous ...	4	1
17. Sarcoidosis and collagenous diseases	2	—
18. Pleural thickening or calcification—non-tuberculous	29	41
19. Abnormalities of the diaphragm and œsophagus — congenital and acquired	12	9
20. Congenital abnormalities of heart and vessels	10	4
21. Acquired abnormalities of heart and vessels	50	111
22. Miscellaneous	11	3
23. Enquiries not completed	43	40
	<hr/> 418	<hr/> 614

Care and After-Care.—Much of the work undertaken for the care and after-care of the tuberculous patient and the family remains unrecorded, being the combined work of the general practitioner, divisional health staff, chest physicians, Welfare and Children's Departments, National Assistance Board, Local Housing Authorities, Ministry of Labour and National Service, Employers' and Employees' organisations and voluntary help.

Ten patients whose condition did not permit of their return to normal competitive employment were admitted to the training settlements at Papworth (6), and Sherwood (4). Seven were discharged for various reasons and at the end of the year, there were thirteen in residence at Papworth (8), Sherwood (4), and Enham Alamein (1). In addition there are a number who have been successfully absorbed in the village settlement at Papworth and for whom the County Council no longer has any direct responsibility.

Extra nourishment, consisting of up to two pints of milk daily, continues to be available for domiciliary patients suffering from active tuberculosis; 8,810 grants were made during the year and 1,300 patients were receiving this nutritional supplement at the end of the year at a cost of rather more than £25,000 a year.

Domiciliary open-air shelters, beds, mattresses and bedding are provided to facilitate the segregation of the tuberculous patient who continues to reside at home.

With the kind co-operation of the County Welfare Officer, it has been possible to launch a pilot scheme for the provision of handicrafts instruction for domiciliary tuberculous patients, 12 of whom were receiving such instruction at the end of the year. Similar facilities have been afforded in exceptional cases but the possibility of a general expansion to other parts of the County area will be reviewed in the light of experience of this pilot scheme.

Grants from the West Riding Distress Fund have been made, occasionally for clothing, but more generally for the payment of travelling expenses to enable family relatives to visit the tuberculous patient whilst undergoing hospital treatment.

The nine Voluntary Care Committees provided services covering some 42 per cent. of the county population. That at Pontefract is meeting with difficulties, but elsewhere they are now firmly established. The function of a Care Committee is to seek to ameliorate the many problems, financial and other, which beset the tuberculous patient and his or her family. The aid directly available from the County Council is restricted to the person who is suffering from tuberculosis, and excludes the family, spouse or children, who may need special care to minimise the possibility of infection or to relieve the continuous strain of marital care. National Assistance is restricted to the patient who is the bread-winner, although a non-earning wife or dependent may be the patient and by the nature of the illness, be making an unwonted strain on the resources of a low wage. These are the more obvious instances illustrating the advantages of an organisation readily available to meet needs which cannot be satisfied by statutory authorities. Less obvious is the personal attention which can be given, particularly at Christmas each year; the local library service; help with diversional therapy; the personal interest in social problems and in matters affecting employment. Indeed, although a brief summary of the items of expenditure is possible, it is only from a careful scrutiny of the annual reports and from discussions with members of the Committees that a full appraisal of their value can be made. In reviewing the work undertaken by these voluntary organisations, the County Council sought to relate the grants-in-aid to the expenditure directly incurred on benefits for the patient and his or her family, and authorised grants totalling £855. In this way the Committees will be encouraged by the knowledge that any expanded service is likely to be rewarded by an increased grant.

Mental Health

During 1955 Care and After-Care was provided by the Mental Health Social Workers for 639 mentally ill persons, involving upwards of 3,000 visits in respect of such persons, the majority of whom had been discharged from Mental Hospitals, Out-patient Clinics or the Armed Forces. In a few of these cases the Home Teachers visited and gave instruction in occupations suitable to their needs. In a minority of cases care and guidance were provided in the hope of avoiding admission to Mental Hospital with the consequent break of the rhythm of the lives of the persons concerned, some of whom were able to receive the treatment required at Out-patient Clinics. There were also 191 persons (mostly old people), with respect to whom the Duly Authorised Officers were asked by the family general practitioner or relatives to institute proceedings for the admission to a Mental Hospital in whose cases the Duly Authorised Officers considered admission to a Mental Hospital was

unnecessary or undesirable. In these cases steps were taken to provide the care required, some being admitted to chronic sick Hospital or to Part III accommodation under the National Assistance Act. In other cases arrangements were made for Home Helps to be provided; Health Visitors and Social Workers undertook regular visits; relatives were persuaded to provide some care or the patients were introduced to Old Folks Clubs and Associations with the result that many were able to overcome a period of depression and self neglect. Generally these old people have gradually withdrawn from their social contacts making early ascertainment very difficult. Early ascertainment must, in most cases, come from the general medical practitioners, relatives or neighbours. Old Folks Associations and neighbours could, no doubt, report to the Medical Officer of Health, Health Visitors, Welfare Officers, the W.V.S., etc., when old people gradually withdraw from any community contacts thus allowing an early assessment of their needs.

Short Stay Care.—During 1955 short stay care was provided in National Health Service Hospitals for 114 mentally defective persons (82 children and 32 adults) under the provisions of Circular 5/52. This provision has proved of great advantage to both patients and parents, particularly where the mother is about to be confined or is ill and has to be admitted to Hospital or where parents have not, in some cases for many years, been able to have a holiday. In such cases, every effort is made to obtain short stay care for the patient.

Venereal Diseases

During the past nine years there has been a decline in the total number of new cases attending Special Treatment Centres.

Table A shows the numbers of new cases of syphilis, gonorrhoea and other conditions in West Riding Administrative County residents attending Special Treatment Centres from 1938 to 1955 inclusive. Compared with the previous year the reduction in numbers was syphilis 3, gonorrhoea 17, and other conditions 21.

In the year immediately prior to the outbreak of World War II there were twice as many new cases of syphilis and more than four times as many new cases of gonorrhoea, but other conditions were less than half those diagnosed in 1955.

The latter group includes diseases such as non-gonococcal urethritis, non specific cervicitis, trichomoniasis, balanitis, etc., in addition to a number of patients who were examined at Special Treatment Centres in order to exclude the possibility of infection but were found to be free from venereal disease.

Non-gonococcal urethritis is the only form of venereally acquired infection which is apparently not decreasing in incidence in the County.

New Cases (compared with previous years). Table A.

Year	Syphilis	Gonorrhoea	Total of new cases of Syphilis and Gonorrhoea	Other Conditions	Total of new patients
1938	346	650	996	503	1,499
1939	403	678	1,081	593	1,674
1940	299	499	798	497	1,295
1941	331	552	883	587	1,470
1942	423	479	902	735	1,637
1943	487	654	1,141	1,344	2,485
1944	413	560	973	1,383	2,356
1945	473	767	1,240	1,419	2,659
1946	723	1,140	1,863	1,859	3,722
1947	573	729	1,302	1,511	2,813
1948	463	550	1,013	1,403	2,416
1949	435	383	818	1,360	2,178
1950	357	304	661	1,447	2,108
1951	247	171	418	1,212	1,630
1952	219	211	430	1,275	1,705
1953	214	182	396	1,228	1,624
1954	178	152	330	1,189	1,519
1955	175	135	310	1,168	1,478

Of particular interest are the figures given in Table B which clearly reveal the gratifying and striking fall in the numbers of new cases of early syphilis (acquired and congenital) since 1949.

Table B.

Year	Early Acquired Syphilis	Congenital Syphilis under 1 year	Total Early Syphilis
1949	158	7	165
1950	76	4	80
1951	58	4	62
1952	19	1	20
1953	9	1	10
1954	7	-	7
1955	6	1	7

The numbers of new cases diagnosed at Special Treatment Centres each quarter of 1954 and 1955 and the stage and type of syphilis are shown in Table C.

New cases of gonorrhoea have now reached the record low level of 135.

New Cases (Quarterly and stage of disease). Table C.

Quarter ended	Acquired Syphilis				Congenital Syphilis				Gonorrhoea		Other Conditions	
	Early		Late		Under 1 yr.		Over 1 yr.		1954	1955	1954	1955
	1954	1955	1954	1955	1954	1955	1954	1955				
31st March ...	2	1	37	36	—	1	6	10	26	31	312	290
30th June ...	3	3	39	24	—	—	9	9	38	31	298	274
30th September ...	—	2	42	35	—	—	8	7	46	40	288	318
31st December ...	2	—	26	33	—	—	4	14	42	33	291	286
Total ...	7	6	144	128	—	1	27	40	152	135	1,189	1,168

Congenital syphilis is a preventable disease. It has been shown that if a syphilitic expectant mother is adequately treated at a sufficiently early stage in her pregnancy her baby will not be infected. Unfortunately one child under one year of age was diagnosed in 1955 as suffering from early congenital syphilis (See Tables B and C).

Cases of this type may occur in spite of the efforts of the County V.D. Social Workers for one or more of the following reasons:—

- Routine blood tests omitted during pregnancy. The majority of women attending ante-natal clinics have serological tests for syphilis taken; but sometimes, if a negative test is reported in the first pregnancy, further tests are not taken in subsequent pregnancies. It may be that in view of the low incidence of contagious syphilis some doctors do not take blood specimens in all ante-natal cases.
- The expectant mother for reasons of her own may attend for ante-natal care too late in her pregnancy for antisyphilitic treatment to be effective in preventing congenital syphilis.
- The expectant mother may become infected with syphilis in the later stages of pregnancy after a blood test has been taken.
- In exceptional cases the serological test for syphilis may give a false-negative result.
- The expectant mother may attend for ante-natal examination and have a blood test taken, but fail to re-attend.

As a rule if a positive result is obtained a second specimen is taken for confirmation, but there is often a considerable and dangerous delay of a month or more between the two tests. As modern serological tests for syphilis have a reasonably high degree of specificity there would seem to be a strong case for advocating that all expectant mothers whose blood reports are positive or doubtful positive for syphilis should be referred without further delay for the opinion of a Consultant Venereologist. It will be seen in Table D that 23 out of 29 suspected cases were found to have syphilis.

Ante-Natal Cases.

Table D.

Patients						Contacts of patients		
No. of positive reports on specimens from ante-natal clinics	No. investigated by Social Workers	No further action necessary	No. referred direct to S.T.C.	No. found to have syphilis	No. found not to be infected	No. of contacts examined	No. found to be infected	No. found not to be infected
34	31	4	4	23	6	31	*6	25

* Of the 6 contacts infected 3 were adults with Late Syphilis, and the remaining 3 were congenital syphilitics aged 2, 5 and 7 years respectively.

The addresses of the Special Treatment Centres at which new patients from the Administrative County attended during 1955 and number of cases of each disease diagnosed are given in Table E.

On aggregate over the whole Administrative County the ratio of new cases of syphilis to gonorrhoea last year was 1.3 : 1. On this basis gonorrhoea would appear to have been relatively more prevalent in the southern-most part of the County where the ratio of syphilis to gonorrhoea was 0.58 : 1.

New Cases (Treatment Centres).

Table E.

Special Treatment Centre	Syphilis	Gonorrhoea	Other Conditions	Total
Barnsley Clinic, Queen's Road	11	3	84	98
Bradford St. Luke's Hospital	16	6	90	112
Burnley Victoria Hospital	—	1	8	9
Dewsbury General Hospital	18	3	60	81
Doncaster Royal Infirmary	24	41	223	288
Goole Bartholomew Hospital	8	2	17	27
Halifax Royal Infirmary	19	12	51	82
Harrogate General Hospital	3	4	46	53
Huddersfield Royal Infirmary	6	9	62	77
Keighley Victoria Hospital	9	5	66	80
Leeds General Infirmary	17	14	131	162
Oldham Boundary Park General Hospital	1	1	3	5
Rotherham, 12, Frederick Street	12	8	84	104
Sheffield Jessop Hospital	2	—	3	5
Sheffield Royal Hospital	4	1	14	19
Sheffield Royal Infirmary	3	3	13	19
Sheffield City General Hospital	—	—	—	—
Wakefield Clayton Hospital	17	18	193	228
York County Hospital	5	4	20	29
	175	135	1,168	1,478

V.D. Social Work.—The staff consists of four whole-time V.D. Social Workers who are all State Registered Nurses with Health Visitors Certificates.

The County has been divided into four areas and each Social Worker undertakes the V.D. prevention and after-care in her area, working under the immediate direction of a Consultant Venereologist who acts as adviser in venereal diseases to the County Medical Officer. They also attend the V.D. clinics in their areas and maintain liaison with the Divisional Medical Officers of Health, Moral Welfare Workers, etc.

A confidential clerk-typist in the central office deals with the clerical and statistical work.

The Social Workers have three main duties:—

(1) Social Work. This is carried out mainly in the Special Treatment Centres where the Social Worker is able to speak to patients in private and help them with a great variety of problems relating to their disease, their family, their home and their work. No figures are available of the number of patients seen in the clinics but during the year there were 724 interviews with doctors and 1,445 miscellaneous interviews in addition to the work referred to above.

(2) Case Finding. Information about suspected cases of venereal disease is obtained from many sources including new patients known to have the disease. The figures given in Table F relate only to those contacts who were reported as possible cases of venereal disease. Of these contacts 84 per cent. were located and persuaded to attend a clinic for examination.

Contact Tracing.

Table F.

Total No. of contacts reported	94				
Located and examined		79			
Not infected			65		
Infected			14		
Already under treatment				3	
Brought under treatment				11	
Syphilis					7
Gonorrhoea					4
Located		11			
Not examined			6		
Transferred to other authority			5		
Not located		4			
Insufficient information			2		
Unable to locate			2		

(3) Case Holding. Known cases of venereal disease may, for a variety of reasons, cease attending before treatment has been completed or tests of cure carried out. In these cases the V.D. Social Workers communicate with the patients by letter or personal visit, find out the reason for defaulting and help patients to resume attendance.

The statistics of the work done in this sphere are given in Table G.

Defaulters.

Table G.

Total number of defaulters	Returned to clinic after visiting	Failed to return	Removed, unable to locate	Transferred	Number of ineffective visits	Number of re-visits
459	281	75	41	62	586	955

Health Education

In the National Health Service Act, health education is associated with the prevention of illness; this choice should be a salutary reminder that the best prevention against ill-health is the achievement of perfect health of mind and body which is the single purpose of health education. Although mentioned separately here, health education is fundamental to all the activities of the Department and to all the subjects dealt with in this Report. One of the most valuable possessions a person can have is good health and every effort is made to impress upon people exactly what good health is, how it can be acquired and how it can be maintained.

The Administrative County contains on the one hand wide sparsely populated rural areas and on the other, parts which are highly industrialised and densely populated, so it follows that propaganda efforts, to gain maximum results, must be directed along the channels best suited to the areas. In the sparsely populated areas the work for the most part is undertaken by the health visitors and nurses when making domiciliary visits, re-inforced by the teaching of children in schools, while in the more heavily populated parts more use is made of visual aids, e.g. posters, films, film strips and exhibitions. Despite these organised public activities it is realised that it is in the home where the seeds of healthy living are sown and it is there where the foundations of health are laid and where the child himself learns early and lasting habits of cleanliness and healthy living. It is in the home where our efforts are concentrated with the visual aids as useful additional complementary media.

During the year approximately 41,000 leaflets covering a wide range of subjects were distributed to the public through the various health workers of the Department. The majority of the leaflets were those of the Central Council for Health Education, the Royal Society for the Prevention of Accidents and the Central Office of Information of the Ministry of Health. Nearly 1,000 posters were displayed throughout the County in clinics, hoardings and shop windows, in addition to which 70 Central Office of Information picture display sets dealing with the following subjects:— Your Children's Feet, Take Care of Your Teeth, Food Poisoning and Death Traps in the Home were also shown.

Divisional Medical Officers have again co-operated with the Central Office of Information in the insertion of advertisements in local newspapers drawing attention to the safeguards afforded by diphtheria immunisation and giving information as to the times and places at which children could be immunised against diphtheria.

A representative collection of film strips is maintained at headquarters from which Divisional Medical Officers and their staffs can borrow. Strips are also loaned occasionally to County District Sanitary Inspectors especially in connection with clean food propaganda although the range of suitable films or film strips available is not very wide. Talks, in many cases illustrated by these visual aids, have been given by Divisional Medical Officers and their staffs at schools, clinics and meetings of parent-teacher associations and it is clear that every opportunity is taken to impart the fundamentals of healthy living to as wide an audience as possible.

The task of organising health education propaganda within the various Divisions rests with the Divisional Medical Officers and Dr. J. Main Russell, whose Division comprising the Urban Districts of Hoyland Nether, Penistone, Stocksbridge and the Rural Districts of Penistone and Wortley has an acreage of nearly 90,000 and a population of approximately 85,450, has supplied the following brief description of the activities in his Division:—

"During the year publicity by means of leaflets, posters and displays has been carried out on Clinic premises throughout the Division. Lectures to mothers at Infant Welfare Centres continue and are well attended. An address given by my Chief Sanitary Inspector to the senior girls of a Secondary Modern School in Hoyland, on 'The Principles of Elementary Hygiene' is an annual event, and judging by their excellent essays written on the subject 'the seed does not fall on stony ground'.

Every endeavour is made to familiarise as many people as possible on matters of Health Education and in my lectures to Parent-Teachers Associations, Divisional Executives etc., no effort is spared to widen their knowledge on the subject of Health and Hygiene.

An ambitious project organised by the Stocksbridge Urban District Council was a Clean Food Exhibition which met with enormous success. The campaign received much publicity from the local press and was well attended. The venue of the Exhibition was the British Hall, Stocksbridge. A large room was used for display purposes and the usual literature made available for distribution to the public. Many firms from all over the Country had sent material for show pieces. The local Co-operative Society had a working model of a Milk Bottle Washing Machine and there were photographs and models of food preparation premises, showing methods they were adopting and using in the interests of Hygiene. An ante-room that had been converted into a small cinema was also used for showing films and for lecture purposes. Special arrangements were made for Senior School children from the district to attend in the afternoons and they had lectures from two local General Practitioners and the Health Visitor. On respective evenings the adults were addressed by the Director of the Public Health Laboratory Service and myself. During the final evening of the Exhibition a lecture was given by a Works Doctor to all Canteen Workers and members of the School Meals Service were asked to attend.

Impartial observers were of the opinion that much good has been done through holding the Exhibition and the tremendous amount of work entailed was well worth the time and effort."

The activities in a rural area are somewhat restricted by lack of suitable accommodation and Dr. G. Higgins, Divisional Medical Officer, whose Division, Thorne Rural District, has an acreage of approximately 38,420 and a population of 33,660, makes the following observations:—

"The main emphasis in this area is placed on teaching in the home by the nursing staff supported by liberal distribution of leaflets and showing of posters. Group teaching with films etc. has been tried but has not proved a success as the people who need the instruction are just the ones who do not attend such groups."

Commenting on the activities in his Division, Dr. D. J. Cusiter, who is Divisional Medical Officer of the Public Health Division which comprises the Urban Districts of Rawmarsh, Swinton and Wath upon Dearne, and has an acreage of nearly 7,000 and a population of 45,780, writes:—

"Instruction and advice on a healthy method of living are two of the most important tasks of County Authorities and District Councils: all work conducted at clinics and school medical examinations and in the home should be based on this principle.

The main Health Educator must be by virtue of her duties the School Nurse and Health Visitor, but the Midwife and the Home Nurse each have an important part to play—the Midwife with the mother and infant, and the Home Nurse with the ever pressing problems of the aged. The Mental Health Teachers have the patient task of training the mentally handicapped to carry out simple tasks.

Apart from the duties which are always in progress special attention was paid to the instruction of mothers attending for the first school medical examination of their child attending the Infants' School. The subjects chosen were Healthy Footwear and Home Accidents to Children. Illustrated leaflets were issued and explained to each mother in the choice of sensible fitting shoes and stockings for her children, so that foot defects due to badly fitting or unsuitable shoes can be reduced to a minimum. Large size posters were discussed with the mothers on the everyday dangers to young children in a normal busy household from unguarded fires, hot liquids, dangerous defective electric power switches, and the ever present hazard of adult medicines and tablets kept in containers within easy reach of children. Discussion with the School Nurse assists in the good relationship which it is essential to build up between mother, pupil and the Health Authorities.

The School Nurses also undertook an intensive drive for head cleanliness in school children—this was accompanied by an individual card system for each child unfortunate enough to require treatment. A film strip in colour was displayed in some of the schools on the Care of the Hair and advice on how to prevent infestation was given at the same time by the Divisional Medical Officer. Enlarged micro photographs were shown to the pupils and in some schools live insects folded in cellophane were projected on the screen by the aid of the projector. Children were instructed how to wash and care for the hair, particular attention being paid to advising the older school girls; free head lotion and instructions in its use were issued to parents. In the course of this work 7,800 children were examined, a total of 28,414 examinations being made by the Health Visitors. By the end of the year we had clear evidence as to which children were chronically infested and efforts are now directed to them, reinforced by home visits. In the last quarter of the year after the Summer vacation, usually the worst quarter of the year the percentage of scholars from two urban districts found to be infested was 1.1 and 1.4 and from the third 4.8, each district showing a 50% reduction in incidence. The efforts will continue and it would appear that they are effective. Over the whole of the year out of the total of 7,800 children examined, 462 (5.9%) were found to be infested.

The Midwives in two of the districts conduct very active ante-natal relaxation classes for mothers having their first baby. In one clinic no less than 98 mothers were referred by the family doctor for this instruction. At such classes talks are given illustrated by coloured diagrams on suitable diet for pregnancy with a particular aim of trying to reduce the number of premature births in the Health Division. These classes are greatly appreciated by the young expectant mothers and are, of course, entirely separate from the ante-natal clinics.

In the Autumn of the year a course in Food Hygiene was organised by Wath upon Dearne District Council in conjunction with the County Further Education Scheme. Seven lectures were given of half an hour duration by the Chief Sanitary Inspector, Mr. Wilkinson. These were followed by half hour film strip or cine film and discussion, the salient points in the films being brought out by the Medical Officer of Health. The Course was well attended, being held from 4-5.15 p.m. and great efforts were made to keep the subject matter simple and yet effective. Good food hygiene will not in my opinion arise from passing legislation only, it has to be supplemented by knowledge. The Course was so appreciated that it is hoped to continue it next year, and, if possible, extend it to other parts of the Division.

These were the major activities on Health Education carried out in 1955 but it must be borne in mind that they are only special items forming part of the whole Health Education drive in the Division which is a continuous process limited only by time and availability of suitable staff. All are not good instructors, it pays to concentrate on those who have a natural inclination for this type of work."

Liaison with the Hospital Service

A service dealing with the care and after-care of persons suffering from illness must endeavour to work in close association with hospitals where the more acute forms of illness are likely to be treated. There is much socio-medical background history which can be provided to assist in the different forms of treatment; solution of personal and environmental problems can contribute largely to recovery and a full knowledge of home conditions can often determine if and when a patient may be discharged home. An advance knowledge of discharge can also ensure that the appropriate domiciliary services are available for immediate application. It was an appreciation of these factors which suggested that the greatest benefit was likely to be obtained where agreement could be reached to enable a liaison health visitor to have direct access to a hospital, to the staff and to the patients. This form of access has been gained at a limited number of hospitals but has not yet been accepted as a general principle. Time has been too short to eradicate former prejudices and suspicions, but it is hoped that the over-riding interests of the patients will, in time, remove the remaining barriers.

Direct liaison with the hospitals in the manner outlined is operating wholly or in part in Divisions 8 (Harrogate), 11 (Castleford), 12 (Pontefract), 18 (Brighouse), 26 (Wath upon Dearne), 27 (Adwick le Street), 28 (Doncaster), 30 (Mexborough), and 31 (Rotherham). The health visitors attended for 590 sessions and paid 405 special visits. Background reports were provided in respect of 2,361 patients and the problems of 2,547 patients were discussed. The needs of 1,756 patients were made known to the Divisional Medical Officer at or immediately prior to discharge. Further analysis shows assistance given by the midwife in 147 cases, home nurse 264, health visitor 1,520 and home help 113; home nursing equipment was provided for 14 patients; the liaison officers undertook 1,279 environmental investigations including 820 home visits and 503 follow-up visits; rehabilitation was arranged in 18 cases; 3 patients were transferred to convalescent homes, 13 to chronic sick hospitals, 8 to other hospitals, and 5 to nursing homes. Thirty-five were referred to the County Welfare Officer, some for Part III accommodation, and 19 children were referred for further investigation at county clinics. Throughout this work, there was cordial relationship with the hospital staff and close co-operation with the general practitioners with whom 1,151 consultations were recorded.

Elsewhere the absence of direct liaison is not to be interpreted as lack of co-operation; indeed, there is every indication that the hospitals are showing an increasing realisation of the advantages of working closely with the Local Health Authority. This is particularly evident when Almoners are seeking to ensure that after-care commenced in the hospital is continued at home, when maternity patients are being discharged early after confinement, when geriatricians seek to arrange priority of admission for aged persons or are anxious to discharge such patients home, and when patients require continued nursing care at home. The situation is admirably summarised by Dr. Battersby, Divisional Medical Officer of No. 4 (Shipley) Division, who writes:—

“Telephone contact by the Almoner with the Health Visitor works fairly well, but generally, information is one line traffic in the direction of the hospital. Indeed, I have frequently observed that reports from hospital are most often directed to the emptying of beds. There is, of course, no objection to enquiries being made to establish that a patient's home is fit to receive him or her, but this is not the sole purpose of hospital liaison. One hospital with a keen Almoner does send regular enquiry forms to advise the Gerontologist on priority admission. Briefly, liaison is fortuitous, well meaning, no doubt, but unorganised and inadequate. This applies equally to General Hospitals, chronic sick accommodation and Mental Hospitals. Due possibly to traditional contact with T.B. Sanatoria and I.D. Hospitals, the efficiency of hospital liaison and after-care is much better.”

Recuperative Home Treatment

Five hundred and nine applications for recuperative home treatment were received during the year. There were one hundred and eighteen (21 per cent.) cancellations, and of the remaining 391, 85 men, 303 women (19 with children), and 2 children were admitted to one or other of the following homes:—

Binswood Short Stay Rest Home, Didsbury; Blackburn and District Convalescent Home, St. Annes-on-Sea; Boarbank Hall, Grange-over-Sands; Brentwood Recuperative Centre, Marple, Cheshire; “Claremont” Convalescent Home, Matlock; Hunstanton Convalescent Home, Hunstanton, Norfolk; N.A.P.T. ‘Spero’ Holiday Scheme; N.E.C.F.S. Convalescent Home, Grange-over-Sands; Semon Convalescents’ Home, Ilkley; Shoreston Hall, Seahouses, Northumberland; Silver Jubilee Home, Heysham; Spofforth Hall, Spofforth; St. Joseph’s Convalescent Home, Freshfield; Valda Convalescent Home, Bridlington; West Hill Convalescent Home, Southport.

One case was awaiting admission at the end of the year.

The N.A.P.T. ‘Spero’ Holiday Scheme has filled a great need for providing recuperation for the domiciliary tuberculous patients whose condition precludes their admission to the normal homes, other than at Shoreston Hall, Northumberland.

A special visit was made to Southport to see the West Hill Convalescent Home which is provided by the District Provident and Family Welfare Society of Manchester and Salford. This was the subject of a favourable report.

The Metcalfe Smith House, Harrogate, was opened towards the end of the year and will be available for suitable patients. This is a new venture administered by the Metcalfe Smith Convalescent Trust (formerly Cookridge Convalescent Hospital), a voluntary charitable organisation which had been encouraged by the promise of support from the County Council.

Particular mention should be made of the invaluable help being afforded at the Recuperative Centres at Brentwood and Spofforth Hall. These are designed primarily to afford recuperation and rehabilitation for mothers with children who, for various reasons, are unable to cope with the normal domestic life. The mother, under careful supervision, is taught or retaught the general principles of housekeeping in a family unit. Every possible assistance is given, whilst the family is in residence, to sort out and adjust domestic, personal and other difficulties. The children are cared for on day nursery lines, with the mothers participating in their care. Both establishments have instituted a system of follow-up after discharge with a view to determining the degree of permanence of the rehabilitative measures. Brentwood also provides accommodation for recuperative care of mothers, with children, living in unsatisfactory home conditions or those suffering from ill-health and lowered vitality due to too rapid child-bearing, depressive surroundings and environment, and possibly, in the case of some mothers, malnutrition.

Provision of Nursing Equipment in the Home

Under the provisions of the National Health Service Act, 1946, there are at present three statutory sources responsible for the provision of appliances and equipment required for the nursing of patients in their own homes; these are the general practitioner, the Hospital Service and the Local Health Authority.

The equipment which may be prescribed by a general practitioner under Section 38 (I) of the Act is restricted to those items included in Part I of the Third Schedule to the National Health Service (General Medical and Pharmaceutical Services) Regulations, 1954, varying from bandages, lint and cotton wool to trusses and vaporisers.

The Hospital Service is responsible either directly or by recommendation to the Ministry of Health Appliance Centre for the supply of surgical appliances required in connection with hospital treatment, or of wheel chairs, etc., for the permanently disabled. The range of appliances which may be provided through this source is not limited, but with the exception of wheelchairs required for a permanent disability, is restricted to those items directly associated with in- or out-patient treatment. The arrangements generally are described in a voluminous memorandum H.M. (54) 56, from which paras. 82-85 are significant:—

"82. *The dividing line between hospital and local health authority responsibility for the provision of appliances and equipment to patients.* The Act contains no simple formula for placing financial or administrative responsibility, and the permanent or temporary, expendable or non-expendable, "tailor-made" or "off-the-peg" nature of the article needed by the patient has no essential relevance.

83. The hospital and specialist services field under Section 3(1) (b) of the Act, though wide, is circumscribed by the words "at or for the purposes of hospitals." By a liberal interpretation of these words the hospitals, in practice, undertake responsibility for providing certain articles (e.g. invalid chairs and tricycles, and crutches) when they are required for more permanent disabilities. This, however, does not mean that local health authorities, in the discharge of their functions, are precluded from providing them.

84. The local health authority field under Section 28 of the Act can, within reason, be practically as wide, but the discharge of its function is entirely permissive for the local authority under its approved scheme. Local health authorities do, in fact, loan invalid chairs and crutches, and are expected to do so in most cases in which the need is temporary. Walking sticks, again, if needed for medical reasons, the local health authority should ordinarily be expected to consider providing. As a concession to convenience hospitals are frequently themselves prepared to loan temporarily, from their own stock, e.g., in cases where the patient is using the article at the hospital and in the course of discharge.

85. On the other hand, local health authorities should not be expected to provide, as part of their Section 28 care and after-care service, articles which are tailor-made to the patient—i.e., unless the local authority choose to do so, the hospital and specialist services should be willing, on specialist prescription, to accept the responsibility if the article has to be tailor-made even though within the very wide powers and responsibilities of local health authorities to provide.”

In addition to the two foregoing sources, the Local Health Authority is empowered, under Section 28 of the National Health Service Act, to supply nursing equipment and apparatus required for patients in their own homes. There is no restriction, other than that imposed by the Authority itself, on the type of equipment which may be issued. The County Council has implemented this permissive function by making available a considerable quantity of such requisites. The smaller items—bed pans, hot water bottles, feeding cups, sputum mugs, etc., are held by the district nurse, and the larger items are held divisionally for distribution as required. At the end of 1955, the larger items of equipment comprised 157 bed-steads (some fitted with self-lifting poles), 261 mattresses, 10 fracture boards, 232 wheelchairs, 53 commodes, 33 cushions, and 25 domiciliary open-air sleeping shelters, as shown in the following table.

							<i>On loan</i>	<i>Available for issue</i>	<i>On loan</i>	<i>Available for issue</i>
BEDSTEADS :										
Single	...	...	...	...	...	...	79	—		
Single, with self-lifting poles	...	...	...	...	...	...	75	—		
Cots, adult	...	...	...	...	...	...	1	—		
Cots, child	...	...	...	...	...	...	2	—		
									157	—
MATTRESSES :										
Dunlopillo	...	...	...	...	...	...	131	3		
Hair	...	...	...	...	...	...	88	3		
Biscuit	...	...	...	...	...	...	10	4		
Water, full and half length	...	...	...	...	...	...	7	7		
Air	...	...	...	...	...	...	5	3		
									241	20
FRACTURE BOARDS									10	—
WHEEL CHAIRS :										
Bath	...	...	...	...	...	...	24	6		
Folding	...	...	...	...	...	...	141	15		
Self-propelled	...	...	...	...	...	...	18	1		
Spinal, adult	...	...	...	...	...	...	1	5		
Spinal, child	...	...	...	...	...	...	1	4		
Stairway, wheel	...	...	...	...	...	...	1	3		
Stairway, carry	...	...	...	...	...	...	1	—		
Miscellaneous	...	...	...	...	...	...	9	2		
									196	36
COMMODES :										
Chair	...	...	...	...	...	...	49	1		
Other	...	...	...	...	...	...	3	—		
									52	1
CUSHIONS :										
Dunlopillo	...	...	...	...	...	...	27	—		
Air	...	...	...	...	...	...	5	1		
									32	1
DOMICILIARY OPEN-AIR SHELTERS									12	13.

There has been a sequence of requests for the provision of special items of equipment, consisting of special reclining chairs required for spastics, walking aids largely required for spastics, stationary high rest chairs and stools recommended as being suitable for rheumatic patients, and in one instance, a special type of tea trolley recommended as being desirable for a certain rheumatic patient. These items of a specialised nature are outside the sphere for which provision had hitherto been made. The articles in question are generally made to an individual specification and having due regard to para. 85 of Memorandum H.M. (54)56, it was thought probable that responsibility for their supply would be accepted by the hospital service. This was not so and the Ministry of Health confirmed this ruling, the effect of which was that the equipment could be supplied only by the County Council under the National Health Service Act; otherwise from private or voluntary resources. In this situation, the decision was made that the County Council would accept responsibility for the loan of equipment, including items designed to an individual specification, required for the nursing or care of a patient in the home, subject to the item in question not being available through the hospital service, either directly or by the Ministry of Health Artificial Limb and Appliance Centre, and to any recommendation for individually designed equipment being supported by a specialist engaged in the hospital service.

By the end of the year the supply of special equipment had been authorised for 6 patients, the equipment consisting of walking aids (3), high rest chair and stool (2) and a hydraulic lifting hoist (1).

Amongst the many requests for the loan of nursing requisites there is the occasional revelation of outstanding devotion and nursing care as exemplified in the following two cases.

A man, now aged 82, has suffered from paraplegia since 1915 and for the ensuing period of 40 years in which wars and political and economic evolution and revolution have changed the face of the world, he has been nursed and cared for by his wife who is now 83 years of age. The man can be got out of bed for short intervals but is heavy and the lifting taxes the strength of his wife who also finds it difficult to climb the bedroom stairs. A request was made that this good lady might be helped by the provision of a smaller type bed which could be placed in the living room. A hospital bed, specially reduced in height, with a self-lifting pole, was supplied.

The second case is of a professional man, aged 60, suffering from disseminated sclerosis; after hospital care he has returned home to the care of his wife. The man is some thirteen stones in weight, is helpless and completely dependent on the ministrations of his wife who again was severely tasked when lifting her husband. After a full investigation, the authority of the Committee was obtained to purchase and make available on loan a hydraulic lifting device with special slings. This is now supplied and the help afforded by the County Council is greatly appreciated by both the patient and his wife.

HOME HELPS

" 29.—(1) A local health authority may make such arrangements as the Minister may approve for providing domestic help for households where such help is required owing to the presence of any person who is ill, lying-in, an expectant mother, mentally defective, aged, or a child not over compulsory school age within the meaning of the Education Act, 1944."

The Home Help Service has been making its continuing and increasing contribution towards the care of the aged in their homes, in the absence of or in substitution for the care which has been traditionally left as the responsibility of the aged person's family. In many cases it must be recognised that this drama is being enacted against a back-cloth of post-war changes, showing a dispersal of the hitherto closely knit family relationship, a much greater employment of women, an inevitable sequence to the inter-wars fashion of small families, and the many other factors which brought into sharp focus the need for the present socio-welfare services. In 1953, the aged and chronic sick cases provided with home helps increased from less than 2,500 to more than 3,200. This rose to more than 4,000 in 1954 and, in the year under review, to almost 4,800, representing an unabating crescendo at the rate of an additional 800 cases each year. There is as yet no evidence of this need reaching saturation point and it is apparent that there will be an early need for a further increase in the authorised establishment. There is evidence, however, of much thoughtful planning in the amount of help being granted to the aged. With a limited establishment, there must be a restricted service if the greater number is to be provided with help, and this has been done by restricting the help to the aged to that needed for essential household duties. This is also in accord with contemporary geriatric thought that the aged should be encouraged to undertake as much of the normal household routine as is within their physical capacity.

Early in the year, the question of providing a course of approved training for home helps received careful consideration. Against the advantages of such training courses, there were the difficulties arising from the employment of part-time staff, many with domestic responsibilities, and the knowledge that in many areas there can be little or no selection of staff. A training scheme would add to the cost of the service without any guarantee of a compensating increased efficiency. With reluctance the project was abandoned, and it is possible that the justification for this decision is to be found in the remarkably few complaints as to the standard of service provided.

Towards the end of the year, a comprehensive review of the service was made to see if there was any distinguishable pattern which would be of general guidance and of assistance in future planning. The most revealing outcome was the absence of any pattern. In areas where there is the higher proportion of aged, there is often a lesser proportion of service devoted to the aged; these include the residential areas where retired people are often remote from their families, but often prefer to make private arrangements for help. The use of the home helps for the acute sick and maternity cases is often determined by the assessment rather than the need. The availability of women to undertake the work is another contributory factor. Some of the complexities of the problem are admirably shown on the accompanying graph on which an analysis of three major factors is illustrated.

Of the 700 authorised establishment, 659 are allocated to the divisions and 41 remain in the Reserve Pool to meet exceptional demands which may arise and cannot be met from the original allocation. The quarterly allocation of 41, 41, 41, 28, from this Pool represented an average demand of $37\frac{3}{4}$, so increasing the divisional allocations to $696\frac{3}{4}$ against which the use of the service represents the employment of 666. This underemployment is a safety margin of approximately one home help for each division, and is the little reserve left to meet any excessive demands arising in the first quarter of 1956, the last of the financial year, 1955-56.

During the year, 9,938 cases received help through the service on which 1,550,188 hours were expended as against 9,195 cases and 1,392,105 hours for the year 1954. The service provided for the aged and chronic sick represented 73 per cent. of the cases and 82 per cent. of the total hours. The number of cases still in receipt of help on the 31st December was 5,161. The statistical details are as follows.

Number of home helps employed at 31st December:—

(i) Whole-time by part-time workers	...	...	...	...	19
(ii) Part-time	...	...	...	...	1,662
TOTAL	...	...	...	...	1,681

Classification	No. of Cases				Total	
	1st Jan., 1955	New	Dis-continued	Remaining	No. of cases	Hours employed
(i) Maternity	71	1,501	1,509	63	1,572	119,695
(ii) Tuberculosis	54	78	72	60	132	25,851
(iii) Chronic sick, aged and infirm	4,106	3,139	2,501	4,744	7,245	1,267,063
(iv) Other	285	704	695	294	989	137,188
Total	4,516	5,422	4,777	5,161	9,938	1,550,188



MENTAL HEALTH.

" 51.—(1) Section twenty of this Act (which requires local health authorities to submit proposals to the Minister for carrying out their duties under certain provisions of Part III of this Act and to carry out those duties in accordance with the proposals) shall apply with respect to the duties of local health authorities under the Lunacy and Mental Treatment Acts, 1890 to 1930, and the Mental Deficiency Acts, 1913 to 1938."

Administration.—The detailed administration of the Mental Health Service of the County Council has been referred by the Local Health Authority to a Mental Health Sub-Committee consisting of 24 members which meets monthly.

The staff of the Mental Health Section of the County Health Department consists of:—

(a) Medical.

The County Medical Officer is responsible to the Mental Health Sub-Committee for the organisation and control of the Mental Health Service and he is responsible for the medical direction of the service.

The local medical administration of the Mental Health Service is undertaken by the whole-time Divisional Medical Officers in the 28 Divisions into which the County has been divided for the divisional administration of the preventive medical services. The Divisional Medical Officers and Assistant County Medical Officers approved for the purpose give certificates in accordance with the provisions of Sections 3 and 5 of the Mental Deficiency Act, 1913, and also undertake the statutory medical visitation of mentally defective persons under guardianship and complete Special Reports and Certificates in accordance with the requirements of Section 11(4)(b) of the Mental Deficiency Act, 1913.

(b) Non-Medical.

(i) Two Senior Clerks act as Petitioning Officers, one of whom hold the Diploma in Public Administration.

(ii) There are twenty-four Duly Authorised Officers under the Lunacy and Mental Treatment Acts (who also perform welfare duties under the National Assistance Acts), most of whom have had many years' experience of the work. Two of the Duly Authorised Officers hold the Certificate of the former Poor Law Examinations Board and one the Lunacy and Mental Treatment part of that examination; 3 possess the Diploma in Public Administration; 6 have attended Extra-Mural Courses on Mental Health at Universities and the local branch of the Federation of Mental Health Workers is very active in arranging lectures for its members and educational visits to Hospitals. In addition certain members of the male staff of the Divisional Welfare Offices have been trained to act as Duly Authorised Officers in exceptional cases such as protracted absence of an Authorised Officer owing to sickness or during holiday periods.

(iii) Sixteen Mental Health Social Workers are employed, one of whom is a qualified Health Visitor and 2 are State Registered Nurses and have acted as Assistant Health Visitors; 1 holds the Diploma of the National Association for Mental Health; 7 have attended Extra-mural Courses on Mental Health at Universities and all have had four to five months' training organised by the County Council prior to being allocated to their duties in the respective Medical Divisions.

Two of the Mental Health Social Workers attend Psychiatric Out-patient Clinics to assist the Psychiatrists by taking case histories of new patients, visits to patients' homes and relatives and acting as liaison officers between the Psychiatrists and other Local Health Authorities or the Authorised Officers.

(iv) There are three Supervisors of Occupation Centres, two of whom hold the Diploma of the National Association for Mental Health and the other has had many years' experience in School Departments of Hospitals; 5 Assistant Supervisors, 1 of whom also holds the Diploma of the National Association for Mental Health and 3 Nursery Assistants are employed in the Centres.

(v) Twenty whole-time Home Teachers of the Mentally Handicapped and 2 part-time Home Teachers undertake teaching in the home or in group classes. Four of the Home Teachers are certificated; 4 hold the Diploma of the National Association for Mental Health and one the Diploma of Occupational Therapy, whilst most of the others have had some years' teaching experience in primary schools or evening institutes. There is an establishment for 24 Home Teachers of the Mentally Handicapped.

(vi) There is an establishment of six Psychiatric Social Workers but no applications have been received from qualified persons to fill these posts.

The Consultant Psychiatrists in Lunacy or Mental Deficiency employed by the Regional Hospital Boards are ever ready to give clinical opinions and advice on medication, either at Out-patient clinics or at the appropriate Hospitals and occasionally by domiciliary visits.

West Riding patients are admitted to 12 different Mental Hospitals but there is no uniform method of co-operation with the Hospitals except that when specific information regarding a discharged patient is requested this is usually forthcoming. The Mental Hospitals do not make full use of the County Social Workers in obtaining background information relating to patients admitted but where advantage is taken of this service the co-operation extends to the supply, where after-care services are required, of information and case histories of patients discharged from the Hospitals, and opportunities for discussions between the Hospital and Local Health Authority Staffs on patients about to be discharged when it is possible for the Social Worker to see the patient whilst in the Hospital and establish friendly relationship prior to discharge. Close co-operation on these lines between the Authority's Staff and the Mental Hospitals is welcomed.

Training of Staff.—The inability to obtain Psychiatric Social Workers is referred to above but every endeavour is made to fit the Mental Health Social Workers to carry out care and after-care of the mentally ill as well as of the mentally defective.

The County Council are anxious that the scope of the training provided should be increased and although it is proposed that two Officers shall be seconded for a Refresher Course promoted by the National Association for Mental Health (in conjunction with the University of Leeds), a course for new entrants to the services, as envisaged in the Report of the Mackintosh Committee, is very necessary. This Authority has endeavoured to provide training for new entrants on the lines given below but now that the Establishment of Mental Health Social Workers is complete there is difficulty in providing the training for individual applicants to fill the occasional vacancies through resignations. Training, however, is still provided for new entrants, as far as possible, on the following lines:—

One month at Oulton Hall (mental defectives) doing ward rounds with nurses, examining case papers and receiving lectures on mental deficiency, elementary psychology, etc., followed by one month at the Stanley Royd Hospital (mental) talking to patients, seeing and assisting with treatments, attendances at Out-patient clinics and Occupational Therapy Department.

One month in the West Riding County Council's Child Guidance Section of the Health Department including Neurological clinics and Child Guidance Clinics. Training in the Mental Health Section of the County Health Department in the historical scope of the work; the statutory and voluntary Mental Health Services and visits to Occupation Centres and practical work with an experienced Social Worker.

The County Council have a scheme whereby the staffs of Occupation Centres and Home Teachers are recommended for the 12 months' course of training provided by the National Association for Mental Health. Those accepted for the course are granted leave of absence for the period of the training and the County Council pay Students 60 per cent of the salary of a qualified Home Teacher during the period of the course and also the course and examination fees. One of the Home Teachers is taking the present course of the Association.

There is close co-operation with all County Services to avoid overlapping, for example, where a mentally defective child is in the care of the Children's Department it is usual to arrange which Department shall undertake the major supervision and keep the other Department informed of the conditions and requirements. There is also very close co-operation with other statutory and voluntary services (Probation, Ministry of Labour and National Service, National Assistance Board, National Society for the Prevention of Cruelty to Children, Women's Voluntary Services, etc.). In some Health Divisions frequent meetings are held at which all Social Welfare branches of the County Council are represented and all other statutory and voluntary Welfare Services are invited.

Lunacy and Mental Treatment Acts.—Action under the Lunacy and Mental Treatment Acts during 1955 was as follows, the figures for 1954 being given in brackets:—

Lunacy Act, 1890, Patients admitted under Section 16, 469 (461);
under Section 20, 231 (206); under Section 21, 47 (39);
under Section 11, 6 (6).

Mental Treatment Act, 1930, Assistance given in respect of patients admitted under
Section 1, 257 (238); under Section 5, 8 (7).

The Duly Authorised Officers were consulted by general medical practitioners or relatives in 191 instances (219) where action under the Lunacy and Mental Treatment Acts was considered unnecessary.

The Medical Superintendents of the Mental Hospitals will arrange, at the request of the Duly Authorised Officers, domiciliary visits either by themselves or members of the medical staffs and advise on the mental condition of individual patients and the action considered desirable.

The Psychiatric Out-patient Clinics and Specialist Services have proved a boon in providing early treatment in difficult cases. An additional Out-patient Clinic was provided during the year at Brighouse in premises provided by the County Council and at which the Mental Health Social Worker for the district attends and provides background and other information for the Psychiatrist.

Dr. F. Appleton, Divisional Medical Officer, and Dr. Vincent G. Crotty, Consultant Psychiatrist, report on the Brighouse Psychiatric Out-patient Clinic, as follows:—

Dr. F. Appleton (Divisional Medical Officer, Brighouse).

"The maintenance of satisfactory mental health is becoming an increasingly recognised and increasingly important part of our work. It falls into three main categories: work with educationally subnormal children who range from the child who is slightly retarded through the one who is ineducable in an ordinary school to the child who is ineducable in a special school, and the adult who needs supervision after leaving school; the after-care of cases who have been in mental hospitals, either as voluntary or certified patients, and work with patients who do not require mental hospital treatment but, unless their condition is recognised early and appropriate advice and help given at this stage, may require such treatment. It is in this third group of people that it is considered that the greatest scope of a preventive mental health service lies.

There still remains in the public mind a fear and an unwillingness to recognise that they, or any of their relatives, are, or could be, mentally ill, and early anxieties and latent symptoms are allowed to progress until they become frank mental illness recognised by all with whom they come into contact. General Practitioners, Health Visitors and Medical Officers associated intimately with children and mothers in the intimacy of their own homes and clinics have an opportunity of recognising their early mental illness. When I was responsible for an ante-natal hostel to which we admitted patients tired and requiring a rest during their pregnancy, it was remarkable how many of these patients were found to be suffering from worries and anxieties, the resolution of which contributed a great deal to their physical improvement. I had felt, too, that cases discharged from mental hospitals for whom we become responsible for their after-care might willingly attend at one of our clinics when they are not so willing to return to a hospital psychiatric out-patient department.

Dr. Affleck, the Regional Psychiatrist, agreed that there was a case for an experiment to be conducted in the establishment of a psychiatric clinic in our own clinic premises and promised to allow us the services of a psychiatrist at one weekly session for an experimental period. The County Education Committee agreed that these premises should be made available and the Health Committee agreed that the Psychiatrist appointed should have the services of our Mental Health Social Worker and the necessary clerical assistance. One of the Assistant County Medical Officers, Dr. Atkinson, who is interested in this type of work, agreed to devote her session allowed for hospital attendance to assistance at this clinic. It was thought best to exclude children of school age who would normally fall under the child guidance provisions of the County Council, but several schoolchildren were referred during the period between one appointment and another in the Child Guidance Service of the County Council. The General Practitioners were all informed about the inauguration of this clinic and since its inception many of them have expressed a great satisfaction at the help they have received.

Run on preventive lines, it was decided at the outset that no drugs or treatment should be given at the Clinic but that drugs should be prescribed by their own Doctor through the National Health Service, and if further treatment was needed this should be arranged through the Hospital Service.

It has been inevitable that late as well as early cases have been referred, and particularly this was so at the beginning, but there have been a fair number of early cases. Dr. Atkinson and Miss Wroe, the Mental Health Social Worker, have willingly worked into the late evening to accommodate people who were working and could not attend until after normal working hours, and Mrs. Cheetham, a clerk in the department, has also stayed long after normal hours. Every endeavour has been made to keep the atmosphere as quiet and as homely as possible, and we have found that after-care cases who would not willingly attend the hospital, readily come to our clinic, and that many have benefitted in doing so.

This clinic has been a great help to the Mental Health Social Worker in helping her to settle their problems but all that we have been able to do would have been useless unless we had had the full co-operation of Dr. Crotty, the Psychiatrist appointed, who has helped us in every possible way.

The clinic was established in June and at the end of 1955 had been running for seven months, and already I consider that it has justified its inception. I hope it will be the fore-runner of others."

Dr. Vincent G. Crotty (Consultant Psychiatrist, Storthes Hall Hospital, Kirkburton, near Huddersfield).

"This clinic was opened on the 28th June 1955, and is, therefore, moving towards its first anniversary. Looked at simply as a psychiatric out-patient clinic it has justified itself: there have been referrals which would average out at about two new cases per session—as many as one man can see if all are to get a proper chance. Those attending have been given time to discuss their problems, and many appear to have benefitted from their attendance.

But in some ways this clinic was a trial balloon. It was held under public health auspices, in a large, formerly private house converted to school health purposes; there was no direct prescribing of drugs (instead letters suggesting this or that medication were sent to the patients' doctors), the functions of nurse and social worker were both carried out by the Local Authority Mental Health Worker, who, fortunately has had experience in both fields, and, as time went on, a female doctor on the public health staff began to help in the clinic and to participate increasingly and usefully in its work.

I had never before been closely associated with a public health group. As a result of my experience in Brighouse I am convinced, thanks to favourable personal contacts and the inevitable recognition of common problems, that personal interchange in the common field of work between the two disciplines is the best approach to giving the community an efficient service. The fact that the clinic was not held in a hospital, but in a converted house, made a difference, too, although I am not sure that I could describe fully what the difference was. I like working in hospitals—both mental and general—but this does not blind me to the fact that there is a quieter and more personal air about the house in Atlas Mill Road, and that this was very appropriate to the many problems which have been discussed there these last months.

The inclusion of suggestions about medication in the reports to the patients' doctors, instead of their being prescribed direct by the psychiatrist, has been at once salutary, rewarding and frustrating. Salutary because it prunes one's powers and drives home the fact, so easily forgotten, that the family doctor is the patient's only doctor, and that all the rest of us should be built around this centre. This dependence on the family doctor is rewarding too, and in almost all cases one sees slow and tiresome recommendations carried out with care and interest.

The clinic was designed to deal with three types of referral: cases referred by general practitioners, after-care cases (in association with the Local Authority Mental Health Worker) and family problems associated with children not of school age. In fact, at the outset we had referred to us in addition a number of schoolchildren. The appearance of a child guidance psychiatrist for the County has made such referrals unnecessary in recent months. Our greatest source of new cases has been the general practitioner. There have been fewer seen for follow-up purposes. Often I have had previous knowledge of the cases referred for follow-up, or of those who have been discharged from hospital. One can, in these circumstances, easily determine whether follow-up interviews are necessary or whether it is sufficient to make a few recommendations to the Mental Health Social Worker. In all cases we make a point of getting the family doctor's consent before we see one of his patients. Oversight accounted for the very few exceptions to this.

A wide range of cases has been covered, but, as was hoped, the majority was made up of those whose distress or symptomatology were related to emotional problems which could be relieved by their being detected and interpreted by someone experienced in the field of human relations.

I suppose it was natural that, at the outset, I should be sent a few patients who had defied all previous attempts to dislodge them from a life of invalidism. I recall one man, in his late thirties, who would not sit down, but stood at the door, fiddling with his cap, and with a look which showed that he was ready to bolt at the first untoward move on my part. He had not worked for years and years—ever since his wife's first pregnancy when he developed anxiety attacks. He had made a longstanding compromise with life: he stayed at home and did the housework—i.e., did the woman's work while his wife went out to earn their daily bread. He had no intention of giving up this arrangement for anybody. But side by side with this there have been all sorts of people who have come regularly and made serious attempts to grapple with themselves. Some need long interviews, others short.

To sum up, I am happy about the clinic. I wish to take this opportunity of thanking those who have made life easy and pleasant there—Dr. Appleton, who thought of the idea in the first place, and who has spared no pains to make it succeed; Miss Wroe, who has been there from the start and who, in addition to her work, makes all the appointments, Dr. Atkinson who already has a foot confidently in both camps, and Mrs. Cheetham who stays late to type letters not only without complaint, but willingly. And finally the patients and their doctors, for whom the apparatus exists, and who are using it with thoughtfulness and goodwill.”

Three of the patients who attended Out-patient clinics and who were visited by the Social Workers were:—

(1) A young professional woman who had suffered from an anxiety state at various stages of her life such as at 11 years when she was unsuccessful in the County Minor Examination; at the age of 15 years when she entered a Grammar School from a Private School; at the time of the School Certificate Examination and later when she entered her profession. After a short period of treatment she was able to make a complete recovery.

(2) A woman who received treatment for depression, disturbed sleep, lack of energy and an impulse to commit suicide. Her symptoms dated from an attack of Endogenous Depression at 18 years when her history showed a strong resentment due to her not entering Grammar School, owing to family circumstances, and leaving school at 14 years. She admitted to a feeling of rejection as a child, although there was no apparent real basis for this. Once the background of her depression was discovered she was helped very much and, after an interview with her husband, she was considered to have made a complete recovery.

(3) A labile intelligent only daughter who found domesticity too much of an obscure, unacknowledged grind and who was frightened of further children. She came under observation due to her nervous condition and depression. She admitted she liked flattery and did not get enough praise and recognition of the work she did. She considered her neighbours to be ignorant and beneath her. She over-valued education. The basis of her illness was a strong snobbery and a home broken in childhood resulting in a social decline. She improved considerably under treatment and the promotion of her husband, which enabled her to enter the unequivocal middle classes, completed the cure.

Difficulty is still experienced at many Hospitals in obtaining accommodation for patients suffering from senile dementia and whilst there has been some improvement generally in the availability of accommodation occasionally suspended Orders have lapsed before accommodation has become available.

From the 1st December, 1955, the designated accommodation at the Fir Vale Infirmary, Sheffield and the Moorgate General Hospital, Rotherham, was closed for male patients who from that date were admitted to the Middlewood Hospital and the Regional Hospital Board stated that at an early date this designated accommodation would also be closed for female patients. There has been some concern at the closing of the designated accommodation at the Fir Vale Infirmary and Moorgate General Hospital as it has been feared this may cause further delays in obtaining accommodation and, for those patients in the South of the Riding who live in the Storthes Hall catchment area, additional inconvenience and expenditure to relatives in having to travel to Kirkburton rather than to Sheffield or Rotherham. Until December most of these patients dealt with under Section 20 were admitted to Fir Vale Infirmary or the Moorgate General Hospital.

Mental Deficiency Acts.—During 1955, 228 persons were reported to the Local Health Authority as alleged mentally defective persons of whom 15 had not been confirmed as defective by the 31st December, 1955, and 7 had not been found “subject to be dealt with.” The remaining 206 were reported as follows:—By the Local Education Authority under Section 57 of the Education Act, 1944: Sub-Section (3), 79, and Sub-Section (5), 91; by Police or Courts, 4; and from other sources, 32. These 206 mentally defective persons were dealt with as follows:—Placed under Statutory Supervision, 196; admitted to Hospital, 8; admitted to an Approved Home, 1; admitted to an Approved School, 1. Of the 7 who were not found “subject to be dealt with” 5 were placed under Voluntary Supervision and no action was necessary with regard to the remaining 2. The total number of ascertained mentally defective persons in the Administrative County on the 31st December, 1955, was 4,321:—Under Statutory Supervision, 2,155; under Guardianship, 66; in “places of safety,” 3; in Hospitals, 1681; and under Voluntary Supervision, 416. Of the patients in domiciliary care 179 were awaiting admission to Hospital, of whom 84 (including 27 “cot and chair” cases) were in urgent need of accommodation.

TRAINING. Training was considered desirable for 909 of the mentally defective persons under domiciliary care, as follows:

				<i>Under aged 16 years</i>		<i>Aged 16 years and over</i>		<i>Total</i>
				<i>M.</i>	<i>F.</i>	<i>M.</i>	<i>F.</i>	
(a) Occupation Centre	...	...	...	227	192	54	157	630
(b) Industrial Centre	...	...	...	8	—	91	18	117
(c) Home teaching	...	...	...	6	6	24	85	121
(d) Group Training	...	...	...	2	9	7	23	41
				243	207	176	283	909

Of these, 683 were receiving training, as follows:—

	<i>Under aged 16 years</i>		<i>Aged 16 years and over</i>		<i>Total</i>
	<i>M.</i>	<i>F.</i>	<i>M.</i>	<i>F.</i>	
(a) In Occupation Centres	113	101	15	34	263
(b) In Industrial Centres	3	—	9	—	12
(c) At home	17	20	35	84	156
(d) In Group Training Classes	68	63	36	85	252
	201	184	95	203	683

Of the remainder of the mentally defective persons in community care 839 (575 males and 264 females) were in full-time employment and 477 (144 males and 333 females) were considered to be adequately occupied at home.

Three of the 15 Occupation Centres to be provided by the County Council have been established, these being at Castleford, Keighley and Hemsworth. The Hemsworth Centre was opened on the 19th September, 1955, with accommodation for approximately 40 mentally defective persons. A plan and sketch of this Centre are shown on page 83. The Keighley Centre is being adapted to provide accommodation for adult male patients.

A very successful evening class is held by one of the Social Workers for six adult female defectives. The atmosphere is informal and friendly and the girls who attend regularly have made good progress with handwork. An enjoyable trip to Blackpool in June was financed by the Local Branch of the National Association of Parents of Backward Children and the girls' parents were invited to a Party at Christmas.

Reports by the Divisional Medical Officers administering the Castleford, Keighley and Hemsworth Centres are appended.

The County Council have approved adaptations to County properties at Wombwell, Brighouse, Ossett and Horsforth during the 1956/7 financial year for use as small Occupation Centres; to the commencing of the building of a larger Centre at Adwick le Street and to the purchase of sites at Maltby, Chapeltown, Heckmondwike and Castleford.

The County Council's scheme also provides for co-operation by the County Council with other Local Health Authorities in the establishment of joint Centres; for West Riding defectives to be admitted to Centres provided by other Authorities; for the provision of Home Teachers who visit mentally defective persons and care and after-care patients in their own homes; provide training for small groups in clinic and other suitable premises; and also for the provision by the Mental Health Social Workers of some training for defectives in isolated parts of the County. West Riding defectives are admitted to Centres provided by the Leeds, Bradford, Barnsley, Burnley, Dewsbury, Doncaster, Huddersfield, Oldham and Wakefield County Borough Councils and in addition arrangements have been made with the Hospital Management Committee for a few West Riding defectives to be admitted to the Westwood Hospital School, Bradford, for daily training.

CASTLEFORD OCCUPATION CENTRE.

(*Dr. J. M. Paterson, Divisional Medical Officer.*)

The Centre re-opened on January 6th, 1955, with 47 children on the register from the following Health Divisions: eighteen from Castleford, fifteen from Pontefract, five from Rothwell, five from Wetherby, three from Ossett and one from Hemsworth. The attendance was good up to the end of July and although the weather was good when the Centre re-opened on August 29th, the attendances were down and continued low until Christmas, the average attendance being 31 per day.

During the course of the year, seven boys left the centre having reached the age of 15 years, and two girls of that age also left to help at home. One of the boys obtained work at the local Brick Works and another got work at a dairy in Pontefract. When the Hemsworth Centre opened one boy was transferred there and another child was admitted to Westwood Hospital, Bradford.

It was gratifying to find that following the re-assessment of the I.Q. of one of the children attending the Centre, this child was transferred to a residential special school, whilst at a medical inspection of the children carried out in March, the Medical Officer remarked on the continued improvement of the children.

Mrs. Milne Redhead, Inspector of the Board of Control, visited the Centre on May 18th and was impressed with the work of the Centre as a whole. She was agreeably surprised with the Maypole Dancing and was pleased to see that the girls were continuing with plain sewing and darning.

During the year, prior to the opening of the new Hemsworth Centre, Home Teachers and the Junior Staff spent some weeks at this Centre for training and experience.

Thirty children were taken to the Leeds Theatre Royal Pantomime on February 7th and considering this was the first time many of the children had been to a theatre the general behaviour was quite good. The staff were most surprised that the younger children were more interested than the older ones. This outing was financed by the Parent Teachers Association.

Owing to the variety of ages of the children it was decided to have the Annual Outing in two parts—the older children were taken to Filey on July 5th and the younger ones were taken on July 12th. The weather was ideal on both occasions, and the older children were able to have more freedom of movement than in previous years when the whole Centre went together. The behaviour was excellent. Everyone thought this arrangement and outing was the best ever. The outings were financed by the Mental Health Sub-Committee and the Parent Teachers Association.

A May Day and Bring and Buy Sale was held on May 12th, the proceeds of which went to swell the funds of the Parent Teachers Association. This was the first time a real May Day with Queen and attendants had been held, and the Maypole dancing, after two years of constant practice, was mastered to perfection much to the satisfaction of the staff and the delight of the audience. This event was attended by some 60 parents and friends and a repeat performance of the dancing was requested for the Open Day held on July 21st. The Open Day was attended by about 50 parents and visitors. It was opened by the Mayor, County Alderman E. Taylor, accompanied by the Mayoress, Mrs. W. C. Stokes. Also present were Dr. Wood-Wilson, County Medical Officer, the Town Clerk of Castleford and his wife, and several members of the Castleford Borough Council. The Mayor commented on the high standard of the work, especially the physical training display, and the Mayoress admired the needlework and was presented with a set of mats made at the Centre by one of the girls. Tea was provided and served by the parents.

The Rev. G. Craven, Curate to the Castleford Parish Church, again conducted the Harvest Festival Service on September 30th. There was a good attendance of parents and friends, including County Alderman Whittock and Councillor Lowe. The Produce brought by the children was afterwards sold and the proceeds of £7 12s. 5d. given to the Parent Teachers Association Fund.

A sale of Children's Handwork was held on November 22nd, realising £22 12s. 0d.. This brought the total sales of handwork for the year to £32 19s. 11d. The standard and variety of handwork continues to improve, especially the plain sewing done by the girls.

The Christmas Party and Nativity Play was held on December 20th and although the weather was extremely bad the party was a huge success. Some 50 parents and friends attended, including the Mayor and Mayoress of Castleford and other officials. County Alderman Whittock played the role of Santa Claus distributing gifts to the children bought by the Parent Teachers Association. The hard work entailed was amply rewarded by the messages of congratulations and appreciation received.

The Parent Teachers Association continues to run smoothly and has had its second successful year. Various functions have been held including Beetle Drives, a Bring and Buy Sale and a Jumble Sale. Two of the Vice-Presidents, Mrs. Newbould and Mrs. Goodall, have supported us well and have been most generous during the year. The Association presented the Centre with a new Singer Sewing Machine for the use of the older girls, they also bought a Santa Claus outfit for use at our Christmas parties.

BRANSHAW VIEW OCCUPATION CENTRE, KEIGHLEY.

(Dr. H. M. Holt, Divisional Medical Officer.)

The number of children in attendance at the Centre has increased from 27 on the 30th November, 1954, to 33 on the 30th November, 1955. The number of names on the register was 36 in November, 1954, as against 42 in November, 1955, in the following age groups:—

AGES OF CHILDREN ATTENDING THE CENTRE.

Aged — Years

Sex	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
M	1	1	2	4	3	4	2	2	2	—	3	2	—	—	—
F	—	1	—	1	1	2	2	2	3	—	—	1	2	—	1

The staff continue to work harmoniously together and the Supervisor exercises care and tact in maintaining discipline throughout the whole of the Centre's activities. The premises are clean and well kept.

All members of the staff have attended the School Clinic in the course of their work in order to obtain a little guidance at the hands of the speech therapist in dealing with this class of case.

The Parks' Superintendent of the Keighley Corporation has undertaken to keep the grass trimmed at the Centre. The grounds provide for an excellent display and for the training of the older boys in simple horticulture.

A very successful outing was arranged for the children on the 18th July when they were taken by coach to Morecambe. We were fortunate in obtaining the help of the W.V.S. at Morecambe who assisted in the supervision of the children. The Committee approved an expenditure of £15 to cover the cost of the trip but the Parent Teachers Association has agreed to contribute to the cost of future trips.

The adaptation of the second floor for the accommodation and training of older male defectives is still in course of completion.

Finally I would add that the relationship between the Staff of the Centre and the parents of the children is most cordial and the work done is highly appreciated.

HEMSWORTH OCCUPATION CENTRE.

(Dr. J. S. Walters, Divisional Medical Officer.)

The Centre was opened for the reception of children on the 19th September, 1955. The initial arrangements were complicated by the illness of the Supervisor a few weeks prior to the opening and the Home Teacher who acted as temporary Supervisor was left to formulate a programme and syllabus which would meet the emergency and yet be sufficiently flexible to allow adaptation to the Supervisor's own wishes when she was able to take over her duties. The children were admitted in three groups, one group at a time, commencing with the youngest, at weekly intervals. This enabled the teachers to get to know the children and allowed the children to get used to meeting in a group larger than the classes they had previously attended and to learn the discipline of a Centre. As the other pupils joined them, the younger ones felt secure in their superior knowledge of the Centre and thus an even tenor was established without strict discipline but encouraged and fostered by happiness and a sense of belonging to their own establishment and community.

The six adult boys on the waiting list were not admitted, pending the appointment of a male teacher.

The early weeks were taken up with learning a routine of arrival, personal hygiene, assembly, community behaviour, dressing and departure, with emphasis at all times on general conduct, duties to one another and behaviour at meal times.

Later, they began to learn simple number games, birthdays, calendars, nature charts, singing, nursery games, team games, look and say methods, simple recognition and sense-training apparatus, and attention was being given to road sense training.

Skeleton timetables were used and maximum elasticity allowed at first, with a gradual development towards a regular timetable. The individual teacher was allowed room to manoeuvre, which is essential when time has to be conserved by reason of moving furniture and the necessity to lead and persuade rather than order these children.

ATTENDANCE. This has been remarkably good — in each case the reason for absence has been genuine and strong.

HEALTH. One term medical inspection was held. Apart from colds to which these children show a more than normal susceptibility, their health has been good and somewhat better than the normal experienced at home, according to general impressions gained from contact with parents. In two cases only have there been exclusions by reason of dirty hair. Milk was taken each morning by all but two children.

TRAINING. The usual subjects were taken in accordance with the standard syllabus, but it must be borne in mind that this is a new Centre and the basic routines were at first all important; without these as a sure foundation nothing could be built and nothing subsequently achieved.

Handicrafts were utilised in a dual capacity to encourage manual dexterity and also a knowledge of the use of tools and materials, quantities and measurements.

Emphasis on domestic and household science for the older girls also served a dual purpose. Their earlier lessons resulted in the making of towels, dishcloths and other toilet necessities, waste paper baskets, ornaments and other small items for use in the Centre. By assisting with the younger children, they learned several duties in ordinary domestic routine; they warmed the dishes for lunch, collected laundry and checked it (and, on occasions, actually washed it), baked cakes and other simple culinary efforts.

TRANSPORT. Public transport is used wherever possible, paid escorts being employed in addition to the two Nursery Assistants who also carry out escort duties. Taxis are used for two areas where bus services are too infrequent and the unsuitability of certain of the children to travel on service vehicles.

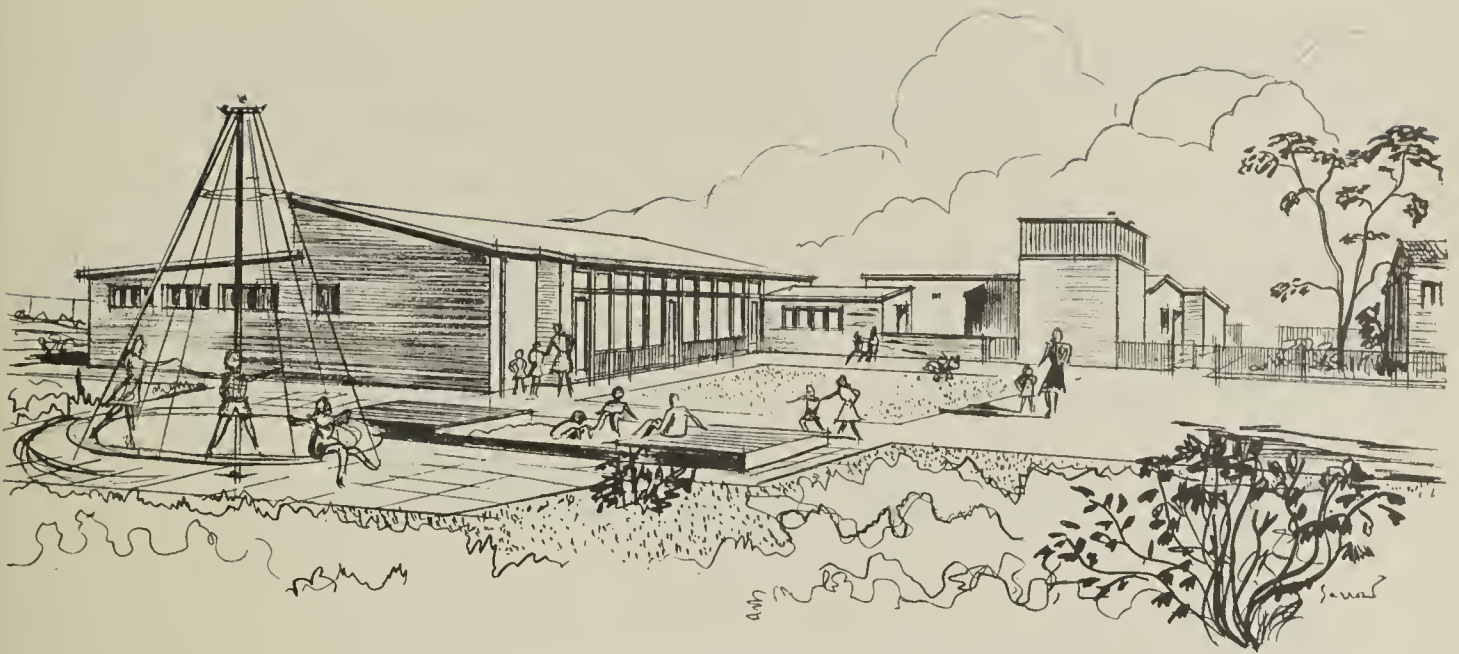
STAFF. The two Nursery Assistants had previous experience in dealing with children but little in dealing with defectives but they both settled down remarkably well. Their love and care for and understanding of the children were reciprocated. They responded to the temporary Supervisor's expressed wish that whatever was to be achieved must be through kindness and a happy atmosphere was almost immediately established. This has been a subject of comment by all who have visited the centre. The fact that these children, who are very sensitive, will respond readily and well to kindness has been abundantly demonstrated.

There has been a growing community sense in the children. They no longer feel outcasts, nor are they as much aware of any abnormality in themselves. Now they have "their own School" and "their own teachers" and they are quite proud of it and are heard to talk of it in a possessive fashion with pride and affection. This has the effect of giving them confidence which in turn has brought ability in some measure, but above all has enabled the children to behave in public. This is most noticeable in connection with the 'bus travel to the centre. At first there was almost chaos with worry and anxiety for the escorts; some complaints from passengers who did not understand and accompanying frustration, especially on crowded 'buses. Latterly there has been more orderly behaviour and a crop of compliments for the escorts. The staff of the 'bus company look out for them and enquire after them.

The need for extra Staff became obvious as all the places were filled and Committee approval to an increase in the establishment was being sought at the end of the year.

CONCLUSION. It is obvious that the Centre meets a definite need and its work will have lasting effect upon this generation of needy children. It is hard but satisfying work and progress, though slow, is already perceptible.

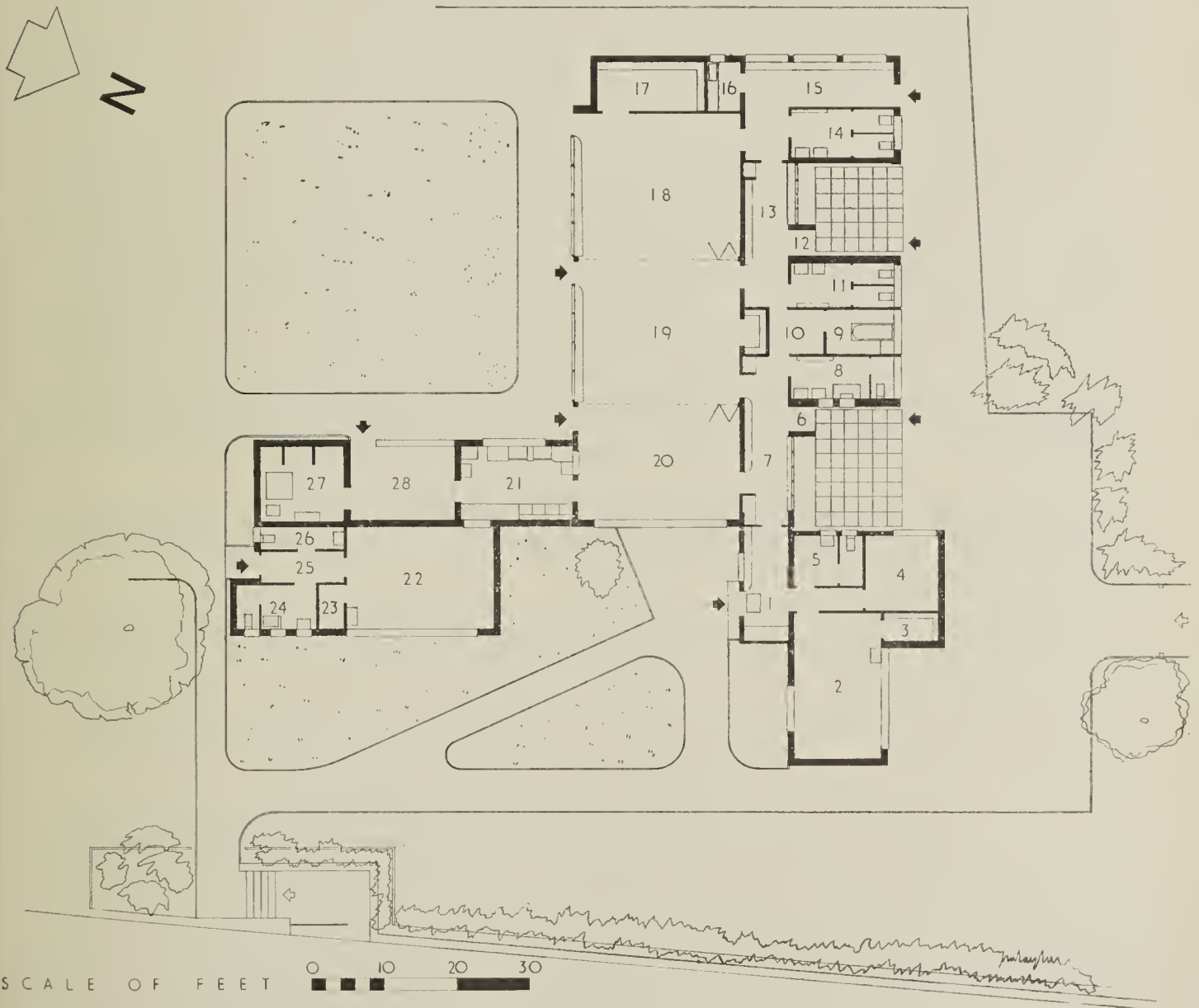
The formation of a Parent Teacher Association was not attempted but was purposely left to the permanent Supervisor upon her taking over her duties.



HEMSWORTH OCCUPATION CENTRE

KEY:

- | | | |
|---|-------------------------|--------------------------|
| 1 Visitors' Entrance Hall | 9 Bathroom | 19 Classroom |
| 2 Supervisor, Medical Inspection and Committee Room | 10 Drying Room | 20 Dining Room |
| 3 Store | 11 Girls' Lavatory | 21 Servery |
| 4 Staff Room | 12 Girls' Entrance | 22 Men's Handicraft Room |
| 5 Female Staff Lavatory and Cloakroom | 13 Girls' Cloakroom | 23 Store |
| 6 Boys' Entrance | 14 Children's Lavatory | 24 Men's Lavatory |
| 7 Boys' Cloakroom | 15 Children's Cloakroom | 25 Lobby |
| 8 Boys' Lavatory | 16 Cleaners' Store | 26 Male Staff Lavatory |
| | 17 Toys and Equipment | 27 Boiler House |
| | 18 Classroom | 28 Yard |



GROUND FLOOR PLAN

PART V

ENVIRONMENTAL HYGIENE

Milk

The County Council has again carried out its obligations as a Food and Drugs Authority (Section 64 of the Food and Drugs Act, 1938) and as a Licensing Authority for the Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949-53.

The following list gives the names and addresses of licensees at the 31st December, 1955:—

PASTEURISED MILK.

Busfield & Hargreaves, Rawson Dairy, Rawson Street, Old Fold, Farsley, Near Leeds.
 Crawshaw, J., Blake Lea Dairy, 103 Arksey Road, Bentley, Near Doncaster
 Doxey, C., Armthorpe Dairy, Armthorpe, Near Doncaster.
 Dobson's Dairies, Ltd., Coates Factory, Barnoldswick.
 Doncaster Co-operative Society, Ltd., York Road, Doncaster.
 Goole Co-operative Society, Ltd., Centenary Road, Goole.
 Harrison, R. H., Manor Farm, Conisbrough.
 Kirkby Malzeard Dairy Co., Ltd., Kirkby Malzeard, Near Ripon.
 Laurence, N. L. & J. E., The Dairy, Bramhope, Near Leeds.
 Mawer, J. & Sons, Glentworth House, Skellow, Near Doncaster.
 Ivanhoe Dairy, 37 Church Street, Conisbrough.
 Mudd, Miss B. J., Aldborough Dairy, Aldborough, Boroughbridge.
 Oates, J. E. & E., Ltd., North Eastern Road, Thorne, Near Doncaster.
 Pontefract Industrial Co-operative Society, Ltd., Horsefair, Pontefract.
 Rotherham Co-operative Society, Ltd., Progress Drive, Bramley, Near Rotherham.
 Salmon, P. J., Orchard House, Littlethorpe, Near Ripon.
 Stocksbridge Co-operative Society, Ltd., Shay House Lane, Stocksbridge.
 Victoria Road Dairy, Ltd., Burley in Wharfedale, Near Leeds.
 West Marton Dairies, Ltd., West Marton, Near Skipton.
 West Riding Dairy Farmers (Wholesale), Ltd., Allan Park Dairy, Sowerby Bridge.
 Wharfedale Creamery Co., Ltd., Bolton Bridge Road, Ilkley.
 Whittaker's Wholesale Dairies, Ltd., 77 Tenter Balk Lane, Adwick le Street.
 Wholesale Dairies (Rotherham and District), Ltd., Claypit Lane, Rawmarsh.
 Wild, A., Prospect Farm, Grotton, Near Oldham.
 Windhill Co-operative Society, Ltd., Thomas Place, Windhill, Shipley.
 Yates, A. E., 822/824 Halifax Road, Hightown, Liversedge, Cleckheaton.

STERILISED MILK.

Wholesale Dairies (Rotherham and District), Ltd., Claypit Lane, Rawmarsh.

All premises licensed to produce pasteurised and sterilised milk were visited regularly and inspections carried out in order to ascertain whether the conditions attached to the licences were being observed and for the purpose of checking the temperatures of milk under treatment, cleanliness of premises etc., and, in general, to see that the plant and other equipment were satisfactory.

The following conditions apply to milk in relation to which the special designation "Pasteurised" is used:— The milk shall be pasteurised, i.e.:—(a) retained at a temperature of not less than 145°F. and not more than 150°F. for at least thirty minutes; this is the "Holder" system and is in use at 12 of the dairies: (b) retained at a temperature of not less than 161°F. for at least fifteen seconds; this is the "High Temperature, Short Time" system and is in use at 14 dairies. All treated milk must be immediately cooled to a temperature of not more than 50°F.

Samples of pasteurised milk are subject to the phosphatase and methylene blue tests. The former is to prove the efficiency of the treatment as to whether or not the milk has been properly pasteurised, or whether any raw milk has become mixed after treatment. The methylene blue test shows the keeping quality.

Sterilised milk shall be filtered or clarified, homogenised and heated to and maintained at such a temperature, not less than 212°F. for a period as to ensure that it will comply with the prescribed turbidity test.

Samples obtained during the year, with results of the examinations, are as set out below:—

	Number	Phosphatase Test		Methylene Blue Test		Turbidity Test	
		Satisfactory	Un-satisfactory	Satisfactory	Un-satisfactory	Satisfactory	Un-satisfactory
Tuberculin Tested (Pasteurised)	78	76	2	78	—	—	—
Pasteurised	478	467	11	476	2	—	—
Sterilised	22	—	—	—	—	22	—

Investigations were carried out regarding the unsatisfactory results and the Chief Area Milk Officer of the Ministry of Agriculture, Fisheries and Food was informed in each instance, as well as the Ministry of Food, Milk Division, Thames Ditton, Surrey.

Copies of all sample reports are forwarded to the Medical Officer of Health concerned.

Sampling of Milk produced at Hospital Farms.— During the year, from March to November, at the request of the Ministry of Health, samples were obtained at 8 farms attached to the hospitals shown below and reports are as follows:—

Hospital	Methylene Blue Test		Biological Examination
	Number obtained	Satisfactory	
Menston, Nr. Ilkley	12	9	4 samples were obtained at each farm and Laboratory examination showed all to be tubercle free. Examination for Brucella Abortus revealed one positive sample viz:— Middlewood Hospital Farm, 6th May, 1955. "Agglutination 1/80, Culture, Positive."
Middleton, Ilkley	12	9	
Scalebor Park, Burley in Wharfedale	12	7	
Storthes Hall, Kirkburton	12	9	
St John's, Wheathead, Keighley	12	11	
Stansfield View, Todmorden	12	12	
Stanley Royd, Wakefield	12	10	
Middlewood, Nr. Sheffield	12	9	

Arrangements are made for immediate notification to the Ministry of Agriculture, Fisheries and Food in the event of any positive biological reports.

"Specified Areas" for the Sale of Milk.—Section 19 of the Food and Drugs (Milk, Dairies and Artificial Cream) Act, 1950, provides for the compulsory use of special designations for the purpose of all sales of milk by retail for human consumption where the place of sale is in an area specified under Section 23 of the Act to be known for the purposes of the Act as a "Specified Area." The Section has the effect in a "Specified Area" that no milk other than milk of a special designation (pasteurised, sterilised or tuberculin tested) may be sold by retail in that area, and any person who sells milk without it being milk to which a special designation applies is guilty of an offence.

During August a firm of milk distributors was fined a total sum of ten pounds on two charges of selling milk by retail for human consumption without the use of a special designation, contrary to Section 19 of the Food and Drugs (Milk, Dairies and Artificial Cream) Act, 1950. The proceedings were instituted by one of the County Sanitary Inspectors in co-operation with the Sanitary Inspector for the Urban District wherein the offence was committed.

During the year one "Specified Area" came into operation, viz.: 21st March. Milk (Special Designations) (Specified Areas) Order, 1955, which included the Urban Districts of Aireborough, Horsforth, Ilkley and Otley, along with the Wharfedale Rural District.

Surveys were carried out by the County Sanitary Inspectors in each of those districts and the following table shows the number of milk retailers, caterers and shops at which milk is sold:—

					Milk Retailers	Catering Establishments	Shops Selling Milk
Aireborough U.D.	...	...	...	...	34	56	14
Horsforth U.D.	...	...	...	...	13	17	22
Ilkley U.D.	...	...	...	...	28	99	3
Otley U.D.	...	...	...	...	21	36	3
Wharfedale R.D.	...	...	...	...	19	14	1
					115	222	43

At the end of the year the following County Districts were included in "Specified Areas":—

Municipal Boroughs—Batley, Brighouse, Morley, Ossett, Pudsey, Spensborough.

Urban Districts — Aireborough, Cudworth, Darfield, Darton, Denholme, Dodworth, Elland, Heckmondwike, Horsforth, Hoyland Nether, Ilkley, Kirkburton, Mirfield, Otley, Queensbury and Shelf, Rawmarsh, Royston, Swinton, Wath upon Dearne, Wombwell, Worsbrough.

Rural Districts—Rotherham, Wharfedale.

Of the 89 County Districts, approximately one-third are now included in "Specified Areas" and, on the basis of population, again approximately one-third are receiving supplies of designated milk.

Sampling of Designated Milks in Specified Areas

Tuberculin Tested (Pasteurised)		Pasteurised		Sterilised		Tuberculin Tested (Raw)	
Sat.	Unsat.	Sat.	Unsat.	Sat.	Unsat.	Sat.	Unsat.
357	7	424	6	165	—	350	49

In connection with the work entailed in carrying out the duties under this Order, I wish to thank the Sanitary Inspectors in the County Districts concerned for their valuable assistance so willingly given to the County Sanitary Inspectors.

Supply of Milk to School Children (Milk-in-Schools Scheme).—The Provision of Milk and Meals Regulations, 1945, state:—"1. The source and quality of the milk supplied for drinking shall be approved by the Medical Officer of Health for the County or County Borough concerned after consultation with the Medical Officer of Health for any County District concerned and, if the School Medical Officer is a person other than either of the two officers first mentioned, with that officer. 2. If milk which satisfies the requirements (1) of this Regulation is not available, the Minister may approve the substitution thereof of an equivalent quantity of full-cream dried milk suitably prepared for drinking, and if he so approves the Authority shall make that substitution."

Milk is supplied in one-third pint bottles, with drinking straws. The only exceptions to this arrangement are four isolated schools which, of necessity, must be supplied with liquid milk in bulk, distributed by the staff at the school, who supervise the cleansing of the crockery used.

The greater part of the milk supplied is pasteurised, the rest mainly tuberculin tested.

Twenty-eight visits and enquiries were made in connection with school milk supplies, apart from the visits made as a routine measure to contractors who have licences for pasteurised milk production under the Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949-53.

Milk Supplied			
Total Number of Schools	Pasteurised	Tuberculin Tested	Ordinary
1,267	1,234 (97.4%)	30	3

The number of samples obtained and results are as set out below:—

						Total	Satisfactory	Unsatisfactory
Pasteurised	...	...	...	...	...	352	344	8
Raw	...	...	...	...	...	62	49	13
Total	...	...	...	...	...	414	393	21

It is satisfactory to record that approximately 95 per cent. of all school milk samples obtained were satisfactory. The unsatisfactory samples reported were obtained mainly during the excessively hot weather of the summer period and were, with one exception, methylene blue failures.

In connection with the small number of raw milks supplied, these were submitted to examination for tubercle bacilli and no positive reports were received.

Ice-Cream

In the Ice-Cream (Heat Treatment, etc.) Regulations, 1947 and 1948, "ice-cream" includes water ices and any article, under whatever description it is sold, which is so similar to ice-cream as to constitute a substitute therefor; "ingredients" includes sugar and dried egg, but does not include colouring or flavouring materials or fruit, nuts, chocolate and other similar substances; and "complete cold mix" means a product which is capable of manufacture into ice-cream with the addition of water only, is sent out by the manufacturer in airtight containers, and has been made by evaporating a liquid mixture which has already been submitted to heat treatment comparable with that prescribed in these regulations.

The regulations provide that where, in the manufacture of ice-cream a "complete cold mix" is used, which is reconstituted with water, colouring or flavouring materials, etc., the product shall be converted to ice-cream within one hour of reconstitution. In any other case, after the ingredients have been mixed, the mixture shall not be kept for more than one hour above 45°F. before being raised to and kept at a temperature of not less than 150°F. for 30 minutes, or 160°F. for ten minutes. It shall then within 1½ hours be reduced to not more than 45°F. and there kept until freezing is begun.

Ice-cream may not be sold unless kept at a temperature not exceeding 28°F. It must be protected from contamination at all times. All apparatus used must be installed, maintained and operated, and all utensils cleansed and kept clean, to the satisfaction of the local authority.

The following table gives the numbers of manufacturers, retailers, etc., together with the number of inspections made during the year by the County District Sanitary Inspectors:—

	Manufac- turers	Retailers	Producer- Retailers	Inspections Made
Municipal Boroughs and Urban Districts ...	30	3,223	109	3,317
Rural Districts	3	828	31	952

Samples of ice-cream submitted for bacteriological examination are graded according to the time taken to reduce methylene blue, viz.:—

Grade 1 ...	4½ hours or more.
„ 2 ...	2½ hours to 4 hours.
„ 3 ...	½ hour to 2 hours.
„ 4 ...	0.

Samples obtained by the Sanitary Inspectors of the County Districts during the year were as follows:—

	Grade 1	Grade 2	Grade 3	Grade 4
Municipal Boroughs and Urban Districts ...	773	203	96	65
Rural Districts	291	83	35	26
Totals	1,064	286	131	91

Atmospheric Pollution

THE MEASUREMENT OF ATMOSPHERIC POLLUTION—The County Council's Scheme for the measurement of Atmospheric Pollution has continued throughout the year in co-operation with the Department of Scientific and Industrial Research and Medical Officers of Health and Sanitary Inspectors in certain County Districts. Considerable assistance is given by Medical Officers of Health and their staff in supervising the recording instruments and their contribution has helped the scheme to continue operating efficiently.

All the instruments are of standard pattern being in accordance with the specifications laid down by the Department of Scientific and Industrial Research who were also consulted as to the siting of each instrument. The extent of pollution by deposited matter is determined by exposing a deposit gauge for a period of one month and then examining the solid and liquid fractions of the sample collected. The lead peroxide instrument is used for estimating the amount of atmospheric sulphur dioxide, the method being to expose a small cylinder or “candle” coated with lead peroxide to the air for one month and then to have it analysed for sulphates. The processes are repeated each month and the chemical examinations in connection with these instruments thus form a month-to-month record of variations in pollution. The daily smoke filter is used for making regular observations of the daily average concentration of smoke and suspended matter, these terms being applied to particles of soot, etc., which are very small and settle to the ground only slowly or not at all and, therefore, are not collected to any large extent by deposit gauges.

The results of the analyses in connection with the deposit gauges and the lead peroxide instruments, also the average daily suspended impurity as measured by the daily smoke filters are shown in the following table:—

Situation of Instruments	Deposit Gauge				Sulphur Measurements by Lead Peroxide Method SO(3) per 100 sq. cms. per day Average	Situation of Daily Smoke Filter	Average Daily Suspended Impurity Milligrams per cubic metre Average
	Rainfall in inches		Total solids deposited in Tons per sq. mile				
	Monthly Average	Total*	Monthly Average	Total*			
Skipton—Behind Town Hall in industrial and residential area.	2.30	27.63	16.57	198.83	0.76	On top floor of Town Hall, in industrial and residential area.	0.209 for 9 months
Keighley—Abattoir, Hardings Road in mainly open country.	1.63	14.64 for 9 months	12.24	110.12 for 9 months	1.64	First floor of Public Health Dept., in a built-up area in centre of town.	0.144 for 7 months
Keighley—Oldfield, Oakworth in windy moorland country.	1.57	18.88	9.86	118.26	1.53		
Keighley—Low Bridge, dense industrial area.	2.03	24.32	16.97	203.68	1.75		
Keighley—Library, built-up area in centre of town.	2.05	20.46 for 10 months	17.23	172.33 for 10 months	2.38		
Bingley—St. Ives Research Station in parkland and residential area.	1.89	22.67	9.17	110.02	1.29	In grounds of St. Ives Research Station, in parkland and residential area.	0.045
Bingley—Town Hall in manufacturing and residential area.	2.15	23.63 for 11 months	11.64	128.06 for 11 months	0.88		
Shipley—Somerset House Clinic in manufacturing and semi-residential area.	1.03	10.25 for 10 months	13.10	130.99 for 10 months	1.27		
Horsforth—Broadgate Walk, residential area.	1.86	22.28	13.62	163.38	1.55		
Aireborough—Yeadon Moor, Yeadon Waterworks. Agricultural N.W. to S.E., manufacturing S.E. to W.	0.99	10.87 for 11 months	13.75	151.24 for 11 months	1.63 for 11 months	Sanitary Inspector's Office, Yeadon High Street, residential to W., open country to E.	0.107
Otley—Nursery Gardens, Westgate, manufacturing and semi-residential.	1.78	19.60 for 11 months	12.85	141.33 for 11 months	0.80	First floor of Council Offices, in town centre, mainly manufacturing.	0.115
Ripon—Engineer's Depot, residential area.	1.75	19.30 for 11 months	10.21	112.27 for 11 months	0.96 for 11 months	Health Dept., High Skellgate, in centre of country town.	0.124
Harrogate—Roof of Municipal Offices, residential and commercial. Inland Spa.	2.03	24.31	11.21	134.50	1.19	Laboratory, Royal Baths. Inland Spa.	0.075
Wetherby—Council Offices, residential, surrounded by open country from $\frac{1}{2}$ to $\frac{3}{4}$ mile distant.	1.74	19.13 for 11 months	12.04	132.49 for 11 months	0.74	Council Offices, residential, surrounded by open country from $\frac{1}{2}$ to $\frac{3}{4}$ mile distant.	0.123

* For period of full year unless stated otherwise.

Situation of Instruments	Rainfall in inches		Total solids deposited in Tons per sq. mile		Measurements by Lead Peroxide Method SO(3) per 100 sq. cms. per day Average	Situation of Daily Smoke Filter	Suspended Impurity Milligrams per cubic metre Average
	Monthly Average	Total*	Monthly Average	Total*			
Goole—Health Centre, Bartholomew Avenue, residential and industrial.	1.71	17.11 for 10 months	11.61	116.05 for 10 months	1.24 for 11 months	Div. Health Office, in residential and industrial area.	0.218
Castleford—Roof of Marks and Spencer's shop, Carlton Street, in centre of industrial town.	1.67	20.02	17.37	208.40	2.54	First floor of Div. Health Office, in residential area.	0.237 for 10 months
Castleford—Roof of Cleansing Station, Cinder Lane, manufacturing area. Chemical works immediately adjacent.	1.24	12.39 for 10 months	24.54	245.35 for 10 months	4.59		
Castleford—Corpn. Pumping Station, Ings Lane, manufacturing area.	1.18	13.00 for 11 months	15.20	167.25 for 11 months	1.87		
Castleford—Corpn. Housing Depot, Redhill Road, Airedale. Industrial and residential area.	1.46	16.07 for 11 months	11.34	124.77 for 11 months	2.24		
Horbury—Carr Lodge Park, residential and manufacturing to north, open country to south.	1.54	18.46	16.23	194.81	1.78	Sewage Works, $\frac{1}{4}$ mile south of town centre, north manufacturing and residential, south open country.	0.161
Morley—Flat roof of Co-operative Society premises, residential, commercial and manufacturing.	1.82	21.88	19.20	230.41	2.07	†Sanitary Inspector's Office, Commercial Street, in centre of mixed residential, commercial and manufacturing town.	0.206 for 11 months
Batley—Flat roof of one storied building at rear of P. H. Dept., Market Place. Centre of town. Mixed residential, commercial and manufacturing.	1.71	20.46	20.16	241.93	2.07	Public Health Dept., Market Place, in centre of mixed residential, commercial and manufacturing area.	0.233
Rothwell—Central Clinic, Oulton Lane, residential.	1.61	19.29	14.79	177.43	1.66	Div. Health Office, Oulton Lane, in residential district.	0.162
Spensborough—Corpn.'s Depot, Marsh. North, south and west—manufacturing area, open country to east.	1.64	18.06 for 11 months	15.27	167.92 for 11 months	2.55	Div. Health Office, Elm Bank, in industrial and manufacturing area.	0.193
Elland—"Ellen Royd," Public Library in manufacturing area.	1.90	22.78	13.69	164.28	1.98	First floor of Council Offices, in manufacturing area.	0.227 for 8 months
Hebden Royd—Redacre Sewage Works, Mytholmroyd, residential and manufacturing area, open country to the N.	2.29	27.52	16.39	196.69	1.48	Redacre Sewage Works, Mytholmroyd, residential and manufacturing area, open country to the N.	0.119

* For period of full year unless stated otherwise.

†The instrument was moved from groundfloor P.H. Dept., Queen Street, approx. 100 yards South of present site in July, 1955

Situation of Instruments	Deposit Gauge			Sulphur Measurements by Lead Peroxide Method Milligrams SO(3) per 100 sq. cms. per day Average	Situation of Daily Smoke Filter	Average Daily Suspended Impurity
	Rainfall in inches		Total solids deposited in Tons per sq. mile			Milligrams per cubic metre Average
	Monthly Average	Total*	Monthly Average				Total*
Colne Valley—Sewage Works, Slaithwaite, in mixed residential and textile manufacturing district.	2.63	31.57	18.83	2.04	Town Hall, Slaithwaite, in mixed residential and textile manufacturing district.	0.144
Colne Valley—Marsden Park, residential and manufacturing area.	3.12	37.46	19.50	1.46		
Holmfirth—Sewage Works, Neiley, Brockholes, residential and manufacturing.	2.23	24.49 for 11 months	13.28	1.21		
Saddleworth—Sewage Works, Shaw Hall Bank, Greenfield, residential, manufacturing and commercial.	2.15	15.05 for 7 months	17.32	1.69	Sewage Works, Shaw Hall Bank, Greenfield, residential, manufacturing and commercial.	0.115 for 11 months
Wortley—Hallwood Hospital Grounds, Grenoside, open country and woodland.	2.30	25.32 for 11 months	10.83	1.25	Health Department, Council Offices, Grenoside, industrial and manufacturing area.	0.144
Hemsworth—Vale Head Park, parkland, surrounded by open country.	1.49	17.93	11.81	1.70	Div. Health Office, Adiscombe House, in residential district.	0.180 for 11 months
Darton—Grounds of Council Offices, semi-residential, colliery district. Coke by-product plant 1 mile to S.E.	1.67	20.06	14.41	1.17	Council Offices, semi-residential, colliery district. Coke by-product plant 1 mile to S.E.	0.141
Wombwell—The Gables, semi-residential, colliery district.	1.70	20.36	14.06	1.49	The Gables, semi-residential, colliery district.	0.224
Rawmarsh—Roof of Clinic, Barbers Avenue, residential and industrial.	1.42	17.03	20.15	2.07	Sanitary Inspector's Office, in centre of residential and industrial area.	0.364
Rawmarsh—Grounds of Granby House, Aldwarke Road. Blast furnaces 200-300 yards distant.	1.62	19.40	57.36	3.89		
Bentley with Arksey—Bentley Park, Askern Road, semi-residential, colliery district.	1.54	18.43	15.51	1.41	Council Offices, in centre of semi-residential area, colliery district.	0.198 for 11 months
Doncaster—Between Church and Vicarage, Askern. Industrial and residential. Colliery district.	1.49	17.83	38.98	1.51		
Thorne—Grounds of Council Offices, semi-residential, colliery district.	1.36	15.00 for 11 months	10.58	1.02	Council Offices, town centre in semi-residential and colliery district.	0.125
					Maltby—Council Offices, one mile west of town centre, semi-residential, colliery district.	0.136

Situation of Volumetric Sulphur Dioxide Apparatus	Sulphur Measurements by Volumetric Method	
	SO(2) in parts per million	
	Average	
Hebden Royd—Redacre Sewage Works, Mytholmroyd, residential and manufacturing area.	0.048	
Aireborough—Sanitary Inspector's Office, Yeadon High Street. Residential to W., open country to E.	0.032	

* For period of full year unless stated otherwise.

It will be seen from the above table that the deposit gauge recording the highest pollution is at Granby House, Rawmarsh. This gauge was installed in October, 1951 and year by year the average monthly deposit recorded has consistently been far greater than that obtained with any other gauge in the County.

Commenting on the abnormal atmospheric pollution conditions existing in the vicinity of Granby House and the efforts which have been made towards achieving a reduction in pollution, Dr. D. J. Cusiter, the Medical Officer of Health, writes:—

“A standard deposit recording gauge was installed at Granby House in October, 1951, as it had become apparent that there was severe atmospheric pollution in this area, and it was thought desirable that this should be measured scientifically.

The recording gauge is in the open 100 yards due North from two blast furnaces used for smelting iron, and whose combined production is 3,000 — 4,000 tons of iron a week, for a consumption of 3,000 — 4,500 tons of coke in the same period. Two main line railways to York and Leeds and a colliery, are situated one-third of a mile to the East, a chemical works and tar distillery half a mile to the South West. Due North and half a mile distant is another recording gauge at the Clinic, Barbers Avenue.

These two blast furnaces are the only blast furnaces in the Sheffield Area. They are 75 feet high and are circular, hollow, water-cooled, brick-lined retorts, into which loads of iron ore, limestone and coke are automatically fed at the top by mechanical skips which receive their charge from storage bunkers at the furnace base. These bunkers are filled by conveyor belts—the whole process is automatic. The skip travels up an inclined ramp to the top of the furnace 75 feet up. Here it turns over and discharges its contents to the furnace, where it falls on a small bell closing the top of the furnace. The weight forces the bell open and the contents fall to another bell sealing the furnace proper. Below the second bell is the main furnace at the base of which liquid iron and slag are run off whilst refilling takes place at the top. The process is a continuous one week in week out until the brick lining of the furnace burns out years later. The furnace is then put out and re-lined. During the process a vast amount of gas is produced, this is tapped at the blast furnace, led away, cooled and cleansed by electrostatic precipitators. The gas cleansing plant can cleanse 4 million cubic feet of gas per hour. The dust taken out of this gas is washed down by water sprays and removed as a semi-solid sludge — 10,000 gallons of this is removed every 24 hours and dumped. The clean gas is recirculated and consumed.

Co-operation with the steelworks staff has been carried out on a cordial basis, frequent conferences were held and copies of our monthly deposit figures are sent to the directors, who set up in addition their own recording plant.

The following tables show the average monthly total deposit at each of the recording stations over the past 4 years.

Average Monthly Total Deposit Recorded in tons per square mile

Year	Granby House	Clinic, Barbers Avenue
1952	122	19
1953	118	18
1954	70	22
1955	57	20

It will be seen that there has been a 47% reduction in deposit in this period. The deposit was analysed in 1953 by the public analyst and a copy of the analysis is seen below compared with deposit at Doncaster and the Clinic, Barbers Avenue. This illustrates the peculiar nature of the deposit.

	Total Silica	Iron Oxide	Total Ash
Doncaster ... ..	.072 gms.	.032 gms.	.196 gms.
Granby House ... ..	.600 „	1.340 „	2.157 „
Barbers Avenue ... ..	.103 „	.043 „	.180 „

Thus 90% of the deposit at Granby House is due to blast furnace slag being a mixture of coke, iron ore and limestone. It is an exceedingly *heavy deposit* and can be lifted by a magnet. It is not soot for which it is often mistaken and misquoted. An equivalent weight of soot would occupy enormous bulk compared with this heavy deposit. It comes in part from the conveyor belts (which are screened), the skip, and the loading at the furnace top, but the main bulk comes from sudden increases in gas pressure within the furnace due to irregular settlement — these gases lift the two bells at the furnace top, which act as safety valves and carry dry aggregate with them. By using foreign ore with a higher iron content and mixing this with native ore better settlement and more regular working of the furnaces has been obtained cutting down these sudden pressure increases. In 1953 one furnace had an experimental dust arrester fixed at the top and in 1954 in the holiday period the other was similarly dealt with.

The combined efforts of the Company and the local district Council have secured a 47% reduction in the deposit and we are still trying to reduce it further. The interesting point is that owing to its very heavy nature the deposit is confined to the immediate vicinity of the blast furnaces. During this four year period the deposit half a mile away at Barbers Avenue has remained constant at 20 tons per square mile per month an average figure for any industrial area, showing the fall out is maximum within 300-350 yards of the furnaces.

The deposit does not cause silicosis as the silicon is soluble. In February, 1955, 1,255 employees at the steelworks were Mass X-rayed. One case of pneumoconiosis was revealed. This compares with 39 cases of pneumoconiosis found in 926 miners at a nearby colliery. Quite possibly the case at the steelworks was in a miner, but as the individual details are confidential I do not know.

The gauge at Granby House is probably unique in the country in that it was sited for a specific purpose, and its readings are not representative of the atmosphere in Rawmarsh as a whole, and whilst, for purposes of comparison, the readings are quoted in tons per square mile, the maximum deposit is limited to at the most an area of one eighth of a square mile. Owing to the absence of town planning measures when the houses were built, we are now suffering the logical consequences of having houses and furnaces within 100 yards of each other, and remember these furnaces consume as coke, the total output of a small coal mine each week. A problem of this magnitude cannot in my opinion be completely solved by plant alteration, in the long view town planning, in this instance by clearing houses and property, must play a part in the eventual solution.”

In an endeavour to obtain the maximum amount of information concerning atmospheric pollution conditions during periods of “smog” the Department of Scientific and Industrial Research invited the co-operation of Medical Officers of Health and Sanitary Inspectors in certain areas to assist by taking their daily smoke filter readings at frequent intervals during periods of persistent fog. Fortunately the County was relatively free from fog during the year and the arrangements were put into operation on those occasions when the Meteorological Office gave warnings of imminent persistent fog in the area. The study of the results is still proceeding.

Investigations have been made in the past to determine the relationship between atmospheric pollution and deaths from various causes and this matter, so far as the Administrative County is concerned, is discussed on page 15.

In the course of a normal day we consume more weight of air than food or water and we can all play our part in ensuring that these necessities are free from harmful substances. With this in mind I welcome the Government’s Clean Air Bill which by the end of the year had reached the Committee stage and hope that the operative date will not be long delayed.

SMOKE ABATEMENT.—The County District Councils are responsible for dealing with nuisances arising from smoke emission and the following table shows the work carried out by the County District Sanitary Inspectors during the year:—

	<i>No. of observations each of 30 minutes duration</i>	<i>No. of these showing excessive emission of black smoke</i>	<i>No. of cautions issued</i>	<i>No. of statutory notices issued</i>	<i>No. of prosecutions</i>	<i>Bye-laws in force</i>	<i>Districts with colliery spoil-banks</i>	<i>Firing of spoil-banks</i>
Municipal Boroughs and Urban Districts (68)	2,400	227	195	8	—	38	30	18
Rural Districts (21)	96	22	16	1	—	5	9	8

Sanitary Circumstances

Housing.—In the Municipal Boroughs and Urban Districts there were 391,342 dwelling houses and in the Rural Districts 134,264, giving a total of 525,606.

New Houses					Provided by Local Authority		Provided by Private Enterprise	Totals
					Permanent	Temporary		
Municipal Boroughs and Urban Districts	...				4,872	—	2,504	7,376
Rural Districts	...	...	...	...	2,021	—	1,495	3,516

HOUSING CONDITIONS.—The County Medical Officer has again during the year received letters and personal requests from persons in the County Districts who stated they were in need of assistance regarding their existing housing conditions. In every instance the Medical Officer of Health for the district concerned was notified and asked to do whatever was possible.

The following details have been extracted from the Housing Returns furnished by the County Districts:—

	Unfit Houses	Houses not in all respects reasonably fit for habitation	Demolition Orders made	Houses demolished following Demolition Orders	Closing Orders made	Closing Orders determined	Number of cases of overcrowding at end of year	New cases reported during year	Cases of overcrowding relieved during the year	Number of defective dwelling houses rendered fit in consequence of Informal Action by their Officers
Municipal Boroughs and Urban Districts	8,212	14,855	342	282	40	3	1,973	440	690	9,593
Rural Districts	3,212	6,938	202	44	5	—	943	199	365	1,152

HOUSING ACT, 1936: PROCEEDINGS UNDER PART III.

	Municipal Boroughs and Urban Districts	Rural Districts
Number of Clearance Areas represented during the year ...	74	20
Number of houses included in these areas	992	305
Number of persons to be displaced	2,597	649
Action taken during the year in respect of Clearance Areas:—		
(a) by Clearance Orders, number made	50	12
(b) by Compulsory Purchase Orders, number made ...	9	—
Number of houses in Clearance Areas demolished during the year	367	51
Number of persons re-housed from houses demolished during the year	1,060	229
Number of back-to-back houses closed	25	—
Number of persons re-housed	113	—

MUNICIPAL BOROUGH AND URBAN DISTRICTS:—	<i>Housing Act, 1949, Section 4. Action in connection with advances for purpose of increasing housing accommodation.</i>	<i>Housing Act, 1949, as amended by Housing Repairs and Rents Act, 1954. Grants to persons other than local authorities for improvement of housing accommodation.</i>
<i>Aireborough U.D.</i>	41 advances made.	42 grants approved.
<i>Baildon U.D.</i>	—	7 approved, 7 granted.
<i>Barnoldswick U.D.</i>	1 advance—new house.	18—£2,141 4s. 0d.
<i>Batley M.B.</i>	“Yes.”	“Yes.”
<i>Bentley with Arksey U.D.</i>	Loans advanced for the acquiring of houses.	—
<i>Bingley U.D.</i>	5 applications, forming when completed 6 housing units.	43.
<i>Brighouse M.B.</i>	—	42 applications granted in respect of 46 houses. 3 rejected.
<i>Castleford M.B.</i>	—	39 applications received, 38 approved—£6,147. Grants paid £2,390.
<i>Colne Valley U.D.</i>	—	56 grants approved, 40 completed.
<i>Conisbrough U.D.</i>	—	2 grants.
<i>Darfield U.D.</i>	—	Grants to 2 applicants.
<i>Darton U.D.</i>	—	11 grants made.
<i>Dearne U.D.</i>	—	14.
<i>Denby Dale U.D.</i>	7 advances approved.	20 schemes submitted, 19 approved, 18 completed, 12 in progress, 5 approved but not commenced.
<i>Denholme U.D.</i>	—	3 grants.
<i>Earby U.D.</i>	8 advances made.	9 applications approved.
<i>Elland U.D.</i>	—	“Yes.”
<i>Garforth U.D.</i>	120 advances made.	—
<i>Goole M.B.</i>	—	58 grants made.
<i>Harrogate M.B.</i>	—	153 applications considered, 17 dwellings provided by conversion, 40 dwellings approved.
<i>Hebden Royd U.D.</i>	—	13 applications approved—6 were completed. Total amount of grants paid £871.
<i>Heckmondwike U.D.</i>	15 advances made.	6 grants.
<i>Holmfirth U.D.</i>	Applications received.	14 applications—10 approved and grants made.
<i>Horbury U.D.</i>	—	16.
<i>Horsforth U.D.</i>	—	18 applications received, grants approved 14.
<i>Hoyland Nether U.D.</i>	—	5 grants.
<i>Ilkley U.D.</i>	—	28 applications, 28 approved.
<i>Keighley M.B.</i>	—	174 grants approved.
<i>Kirkburton U.D.</i>	—	7 applications granted, 2 completed
<i>Knaresborough U.D.</i>	8 advances.	4 applications received and granted.
<i>Knottingley U.D.</i>	—	45 grants made.
<i>Maltby U.D.</i>	—	7 grants made.
<i>Meltham U.D.</i>	—	12 applications received, 1 withdrawn, 1 not approved, 10 approved, 12 completed (including 5 approved in 1954), 3 not completed.

Housing Act, 1949, Section 4. Action in connection with advances for purpose of increasing housing accommodation.

Housing Act, 1949, as amended by Housing Repairs and Rents Act, 1954. Grants to persons other than local authorities for improvement of housing accommodation.

<i>Mexborough U.D.</i>	—	13 grants.
<i>Mirfield U.D.</i>	12.	14 grants.
<i>Morley M.B.</i>	—	19 grants approved.
<i>Normanton U.D.</i>	—	4 grants.
<i>Ossett M.B.</i>	—	"Yes."
<i>Otley U.D.</i>	—	36 applications, 30 grants approved.
<i>Pontefract M.B.</i>	—	18 applications approved, 4 refused, 3 grants paid. Total amount paid £317 10s. 0d.
<i>Pudsey M.B.</i>	—	77 applications made, 64 grants made.
<i>Queensbury and Shelf U.D.</i>	—	Sum equal to 1d. rate expended during year on grants, 62 houses modernised.
<i>Rawmarsh U.D.</i>	—	Grants for 5 houses.
<i>Ripon City</i>	—	Grants to 3 persons.
<i>Ripponden U.D.</i>	—	6 applications approved.
<i>Rothwell U.D.</i>	—	12 applications considered, 9 approved, 2 qualified for grants.
<i>Saddleworth U.D.</i>	£5,380 in respect of 3 houses.	—
<i>Selby U.D.</i>	One large house altered to accommodate 2 families.	"Yes."
<i>Shipley U.D.</i>	—	16.
<i>Silsden U.D.</i>	—	7.
<i>Skipton U.D.</i>	9 action.	15 grants.
<i>Sowerby Bridge U.D.</i>	—	45 applications, 6 withdrawn, 35 granted, 4 rejected.
<i>Spenborough M.B.</i>	65 advances totalling £36,103.	42 applications approved, grants totalled £4,122 10s. 0d.
<i>Stanley U.D.</i>	—	11 grants.
<i>Stocksbridge U.D.</i>	6 advances made.	7 grants approved.
<i>Swinton U.D.</i>	—	3 grants made.
<i>Todmorden M.B.</i>	—	28 applications considered and 27 approved.
<i>Wath upon Dearne U.D.</i>	—	Grants made.
<i>Wombwell U.D.</i>	—	Grants made in 13 cases.
<i>Worsbrough U.D.</i>	—	Grants to 18 persons.

RURAL DISTRICTS:—

<i>Bowland</i>	—	11 schemes of improvement and 1 of conversion approved. 5 schemes completed.
<i>Doncaster</i>	—	Grants for 17 houses.
<i>Goole</i>	—	Grants to 19 applicants.
<i>Hemsworth</i>	—	13 grants made.
<i>Hepton</i>	—	8 improvements grants made and 1 for conversion.
<i>Kiveton Park</i>	4 for acquisition, 1 for alteration.	Grants in respect of 60 properties.
<i>Nidderdale</i>	—	40 grants approved totalling £5,418.
<i>Osgoldcross</i>	1 advance made.	17.
<i>Penistone</i>	Council will consider applications.	10 applications totalling £3,163 3s. 3d. granted during year.
<i>Ripon and Pateley Bridge</i>	—	63 approved, 12 rejected.
<i>Rotherham</i>	—	30.
<i>Sedbergh</i>	—	2 grants approved.
<i>Selby</i>	1 application received, a grant for purchase of dwelling, £1,250.	9 grants made.
<i>Settle</i>	—	38 applications approved totalling £5,046. 18 schemes have been completed.
<i>Skipton</i>	—	36 applications approved. Total approved expenses in executing improvements £15,765: amount of grant approved £7,882 10s. 0d.: total amount of grant paid in 1955 £608 10s. 0d. in respect of improvements to 4 dwellings.
<i>Tadcaster</i>	"Yes." Council make grants.	43 grants approved, 21 houses improved.

	<i>Housing Act, 1949, Section 4. Action in connection with advances for purpose of increasing housing accommodation.</i>	<i>Housing Act, 1949, as amended by Housing Repairs and Rents Act, 1954. Grants to persons other than local authorities for improvement of housing accommodation.</i>
<i>Wakefield</i>	28 advances.	39 applications.
<i>Wetherby</i>	"Yes."	Grants to 41 applicants and works to 37 houses completed.
<i>Wharfedale</i>	—	15 grants approved, 6 claims paid.
<i>Wortley</i>	Scheme operated in District to a limited extent in connection with loans for house purchase and construction, together with the Small Dwellings Acquisition Act.	35 applications, houses involved 40. Approved 17, refused 9, deferred 6, withdrawn 3. 7 schemes completed involving 10 houses.

HOUSING (RURAL WORKERS) ACTS, 1926-42.—The County Sanitary Inspectors made 256 inspections at cottages for which grants have been given under the above Acts. These cottages are situated in the following Rural Districts:—Bowland, Doncaster, Goole, Hemsworth, Hepton, Kiveton Park, Nidderdale, Ripon and Pateley Bridge, Rotherham, Selby, Settle, Tadcaster, Wakefield, Wetherby and Wharfedale, also some are situated in the outlying parts of Todmorden Borough and Bingley Urban District. The inspections dealt with the matter of tenancies, structural conditions and rents. Detailed reports were made and forwarded to the Clerk of the County Council who informed the owners of any matters in need of attention.

Closet Accommodation.—

Closet Accommodation.—					<i>Total number of closets of all types</i>	<i>Number of closets on the water carriage system</i>	<i>Percentage of closets on the water carriage system</i>
Municipal Boroughs and Urban Districts					432,799	422,199	97.6
Rural Districts	.....	.....	.....	.....	148,956	130,642	87.7
Administrative County	.....	.....	.....	.....	581,755	552,841	95.0

There are approximately 13,250 pail or tub closets in the County Administrative Area.

Closets constructed for new houses numbered 11,195.

Public Cleansing.—In the Municipal Boroughs and Urban Districts tipping by the controlled system is generally in use. Mechanical separation is partly used in one district and almost complete destruction in another.

In the Rural Districts tipping is in general use, with the majority of tips controlled, the remainder semi-controlled.

Water Supplies.—The table below shows the approximate number and percentage of dwelling houses on public supplies:—

	<i>Municipal Boroughs and Urban Districts</i>	<i>Rural Districts</i>	<i>Total</i>
No. of houses	391,342	134,264	525,606
No. of above on public supplies	380,870	124,475	505,345
Percentage on public supplies ...	97.3	92.7	96.1

The houses not on public supplies are mainly to be found in the outlying and isolated parts of the districts.

Details regarding water samples obtained by officials of the County Districts and other Bodies are as set out below:—

	<i>Chemical Analysis</i>			<i>Bacteriological Examination</i>		
	<i>Number obtained</i>	<i>Satisfactory</i>	<i>Unsatisfactory</i>	<i>Number obtained</i>	<i>Satisfactory</i>	<i>Unsatisfactory</i>
Municipal Boroughs and Urban Districts	485	464	21	3,039	2,610	429
Rural Districts	126	122	4	1,519	1,048	471

Particulars regarding the quality, quantity, extensions, closures or restrictions in water supplies during the year:—

Municipal Boroughs and Urban Districts	Quality					
	<i>Satisfactory</i>	<i>Generally Satisfactory</i>	<i>Fair</i>	<i>Very Hard Water</i>		
	65	1	1	1		
	Quantity					
	<i>Satisfactory</i>	<i>Not Satisfactory</i>	<i>Insufficient in parts of area</i>	<i>Shortage during dry spell</i>	<i>Loss of Pressure</i>	<i>Private supply failing during dry spell</i>
	55	5	4	2	1	1
Rural Districts	Quality					
	<i>Satisfactory</i>		<i>Generally Satisfactory</i>	<i>Very Hard Water</i>		
	14		19	2		
	Quantity					
	<i>Satisfactory</i>	<i>Not Satisfactory</i>	<i>Parts of area not satisfactory</i>	<i>Not altogether satisfactory</i>	<i>Parts of area short during dry spell</i>	
	14	3	1	1	2	

Details of extensions, closures, restrictions, etc.:—

MUNICIPAL BOROUGHS AND URBAN DISTRICTS:—

	<i>Extensions.</i>	<i>Closures, Restrictions, etc.</i>
<i>Aireborough U.D.</i>	Shaw Lane Estate	Private water supplies in the West Chevin area.
<i>Barnoldswick U.D.</i>	—	At Elslack and White Moor during drought.
<i>Batley M.B.</i>	To new properties.	—
<i>Bentley with Arksey U.D.</i>	Extensions made.	—
<i>Bingley U.D.</i>	To 31 houses.	Some private supplies dried up during summer.
<i>Brighouse M.B.</i>	To 135 houses.	—
<i>Colne Valley U.D.</i>	Extensions made.	—
<i>Conisbrough U.D.</i>	—	Shortage during summer months at Conanby—water turned off at night.
<i>Darfield U.D.</i>	To new estates.	—
<i>Darton U.D.</i>	—	Throughout the district.
<i>Dearne U.D.</i>	To new houses.	—
<i>Denby Dale U.D.</i>	To Denby and Skelmanthorpe.	Pumping of water from Huddersfield supply still restricted.
<i>Earby U.D.</i>	—	All supplies restricted—9.9.55—9.11.55.
<i>Garforth U.D.</i>	To new estates.	—
<i>Goole M.B.</i>	To new houses.	Only during repair to burst mains.
<i>Harrogate M.B.</i>	To housing estates.	—
<i>Hebden Royd U.D.</i>	—	At Dauber Bridge, Mytholmroyd.
<i>Hemsworth U.D.</i>	To Kinsley new estate.	Lack of pressure at Fitzwilliam and elevated parts of district.
<i>Holmfirth U.D.</i>	To Kirkroyds housing estate.	—
<i>Horbury U.D.</i>	280yds.—4in., Park Grove. 100yds.—3in., Green Lane. 200yds.—4in., Stannard Well. 24yds.—3in., Stannard Well.	—
<i>Horsforth U.D.</i>	To new premises.	Whole township had restricted supply during September and October.
<i>Hoyland Nether U.D.</i>	To housing scheme.	—
<i>Ilkley U.D.</i>	—	Restricted throughout the district during summer.
<i>Keighley M.B.</i>	Extensions made.	—
<i>Kirkburton U.D.</i>	New 6in. main at Lepton.	—
<i>Knaresborough U.D.</i>	To new houses.	—
<i>Knottingley U.D.</i>	To new houses.	—
<i>Meltham U.D.</i>	To new houses.	U.D.C. supply closed from 1.4.55 to 31.10.55 for new pipe line, reservoir to filter house.
<i>Mexborough U.D.</i>	To Highwoods Estate.	—
<i>Normanton U.D.</i>	To new houses.	—

MUNICIPAL BOROUGHs AND URBAN DISTRICTS:—

	<i>Extensions.</i>	<i>Closures, Restrictions, etc.</i>
<i>Ossett M.B.</i>	New housing estates.	—
<i>Otley U.D.</i>	To New Weston Estate.	—
<i>Penistone U.D.</i>	—	Due to drought.
<i>Pudsey M.B.</i>	To housing estates.	—
<i>Queensbury and Shelf U.D.</i>	500yds.—3in. main in Roper Lane.	—
<i>Rawmarsh U.D.</i>	New houses only.	—
<i>Ripon City</i>	—	Due to drought.
<i>Ripponden U.D.</i>	At Rishworth and Kebroyd.	—
<i>Rothwell U.D.</i>	To building sites.	—
<i>Saddleworth U.D.</i>	To four premises.	—
<i>Selby U.D.</i>	180yds.—4in.	—
<i>Shipley U.D.</i>	To two houses.	—
<i>Silsden U.D.</i>	—	In consequence of drought overflow from Silsden reservoir was restricted and finally closed. Water obtained from Bradford.
<i>Sowerby Bridge U.D.</i>	163yds.—2in. 724yds.—3in. 223yds.—4in.	Private supplies at Fieldhouse and Millbank.
<i>Stanley U.D.</i>	To new estates.	Temporary restriction due to shortage in summer.
<i>Todmorden M.B.</i>	To housing estates.	—
<i>Wath upon Dearne U.D.</i>	To ten houses.	—
<i>Wombwell U.D.</i>	To new houses.	—
<i>Worsbrough U.D.</i>	0.514 miles of water pipes.	—

RURAL DISTRICTS:—

<i>Bowland</i>	—	Bolton by Bowland, Gisburn, Tosside and Bashall Eaves.
<i>Doncaster</i>	To new housing estates.	—
<i>Goole</i>	Extensions made.	—
<i>Hemsworth</i>	To new housing estates.	—
<i>Kiveton Park</i>	Extensions made.	—
<i>Nidderdale</i>	At Tancred and Whixley.	—
<i>Osgoldcross</i>	To new estates.	—
<i>Penistone</i>	To Oxspring parish.	In whole area due to drought.
<i>Ripon and Pateley Bridge</i>	At Summerbridge and Dacre.	—
<i>Rotherham</i>	Extensions made.	—
<i>Selby</i>	$\frac{1}{4}$ -mile of 2in.	—
<i>Settle</i>	To new houses.	Due to drought.
<i>Skipton</i>	Extensions made.	At Kettlewell during drought.
<i>Tadcaster</i>	To Toulston School and six private new estates.	—
<i>Thorne</i>	1,073 lin. yds.	—
<i>Wakefield</i>	Extensions made.	—
<i>Wetherby</i>	—	16 private wells abolished.
<i>Wharfedale</i>	Extensions made.	—
<i>Wortley</i>	Skew Hill—six houses.	Skew Hill previously supplied from shallow wells no longer used.

PLUMBO-SOLVENT WATER SUPPLIES.—The periodical examination of water supplies which are known or suspected to possess plumbo-solvent properties has been carried out. There are 64 such supplies in the County. The samples were obtained in pairs:—(a) after standing for 30 minutes in a lead service pipe, and (b) after standing all night in such a pipe. Examinations were made to determine the presence or absence of lead. It is generally considered that a water supply which is plumbo-solvent to the extent of taking up 1/10th of a grain of lead per gallon is dangerous to health and that the plumbo-solvency of such water should be neutralised. During the year 258 samples were obtained from the 64 supplies. In the case of 7 supplies lead was found to be present in quantities considered dangerous to health and appropriate action was taken.

Drainage and Sewerage.—The following details have been extracted from the returns made by the County Districts:—

	Districts reporting parts still requiring sewerage	Districts reporting parts still requiring improvement of sewers	Districts having carried out re-drainage works	Houses not connected to sewers	Districts reporting inadequacy of sewage disposal works	Complaints by Rivers Boards
Municipal Boroughs and Urban Districts (68)	50	23	26	9,382	32	21
Rural Districts (21)	20	13	11	15,205	18	10

MUNICIPAL BOROUGHs AND URBAN DISTRICTS:—

	<i>Sewer Extensions.</i>	<i>Sewage Disposal Works, Extensions and Remarks.</i>
<i>Aireborough U.D.</i>	Shaw Lane, Guiseley.	—
<i>Baildon U.D.</i>	Denby Drive, Knoll Estate.	—
<i>Barnoldswick U.D.</i>	3,300 lin. feet—foul.	—
	2,440 lin. feet—surface water.	
<i>Batley M.B.</i>	—	Sewage to Dewsbury Works.
<i>Bentley with Arksey U.D.</i>	To new estates.	—
<i>Bingley U.D.</i>	—	Short extension to sludge main.
<i>Brighouse M.B.</i>	New length of 21in. foul sewer laid from North Cut to Cromwell Bottom. New 27in. storm water sewer from Oakhill Road to Thornhill Beck Lane, and new surface water sewer.	—
<i>Castleford M.B.</i>	To new housing estates.	To Airedale Sewage Works.
<i>Colne Valley U.D.</i>	1,600yds. to new housing estates.	—
<i>Conisbrough U.D.</i>	Completion of sewers on the Coal Industry Housing Assoc. site.	—
<i>Darfield U.D.</i>	To new estates.	—
<i>Darton U.D.</i>	To Staincross added area.	—
<i>Dearne U.D.</i>	—	At Thurnscoe and Bolton on Dearne.
<i>Denby Dale U.D.</i>	1,069yds. at Clayton West. 30yds. at Upper Cumberworth.	—
<i>Denholme U.D.</i>	40yds.—6in. at Beech Drive.	—
<i>Garforth U.D.</i>	To new estates.	—
<i>Goole M.B.</i>	To new estates.	—
<i>Harrogate M.B.</i>	Extensions made.	—
<i>Hebden Royd U.D.</i>	166yds.—6in. sewer to Dodd Naze housing site, Hebden Bridge.	—
<i>Hemsworth U.D.</i>	To Kinsley housing site.	—
<i>Holmfirth U.D.</i>	Ford Mill to Kirkroyd Bridge, sewer extended to dismantled cesspool Kirk- royds Lane, New Mill.	—
<i>Horbury U.D.</i>	570yds.—6in., Park Grove Estate. 304yds.—9in., Stannard Well Estate. 123yds.—6in.	—
<i>Horsforth U.D.</i>	Melrose Place and Springfield Estates.	Reconstruction of sewage dis- posal works substantially com- pleted.
<i>Hoyland Nether U.D.</i>	To housing schemes.	—
<i>Keighley M.B.</i>	1,070yds. sewer extension to drain Upper Marsh, Oxenhope. 40yds. sewer extension for new houses.	—
<i>Kirkburton U.D.</i>	40yds.—6in. sewer at Flockton.	Septic tank at Colne Bridge over- hauled. Additional percolating filter and Lea Recorder at Kirk- burton works.
<i>Knaresborough U.D.</i>	Mossop's Estate and Crag Top area.	—
<i>Knottingley U.D.</i>	To new estates.	—
<i>Mexborough U.D.</i>	Surface water sewer S.W. corner of dis- trict, Highwoods Estate.	—
<i>Mirfield U.D.</i>	—	Work in progress to new pumping station.
<i>Morley M.B.</i>	Completed Wide Lane sewer, with storm water overflow. Completed Westerton relief sewer, with storm relief overflow. Completed Fenton Dam main infall to sewage disposal works, with storm relief overflow. Completed sewers for Dean Hall hous- ing estate.	—
<i>Normanton U.D.</i>	To Illingworth Avenue and 25 Council houses.	—
<i>Ossett M.B.</i>	To new estates.	—
<i>Otley U.D.</i>	Weston Lane housing development.	—
<i>Penistone U.D.</i>	To new housing estates.	—
<i>Pontefract M.B.</i>	N.C.B. Estate at Townville.	Carlton Works being extended.
<i>Pudsey M.B.</i>	200yds. Woodhall Road, 250yds. Fox- holes Lane, 30yds. Highfield Street.	At Smalewell Works the rising main is now operating and all humus sludge, sludge bed filtrate and decanted tank water is pumped back to inlet channel for retreatment. At Houghside a sludge lagoon has been con- structed. A new sludge bed has also been constructed.

Municipal Boroughs and Urban Districts:—

	<i>Sewer Extensions.</i>	<i>Sewage Disposal Works, Extensions and Remarks.</i>
<i>Queensbury and Shelf U.D.</i>	To newly developed housing site.	—
<i>Rawmarsh U.D.</i>	3,430yds. 15in. trunk sewer and other sewers to housing estates.	—
<i>Ripon City</i>	—	Extensions in progress.
<i>Ripponden U.D.</i>	6in. sewer extended in Rishworth Road for housing estate.	—
<i>Rothwell U.D.</i>	To housing sites.	—
<i>Royston U.D.</i>	To housing development.	—
<i>Saddleworth U.D.</i>	To new houses.	Springhead Works closed. Treatment now by Oldham Corporation.
<i>Selby U.D.</i>	330yds.—9in.	—
<i>Shipley U.D.</i>	To new estates.	—
<i>Silsden U.D.</i>	Skipton Road for new private houses.	—
<i>Skipton U.D.</i>	64yds.—12in. surface water.	—
	110yds.—9in. surface water.	
	289yds.—6in. surface water.	
	432yds.—9in. foul sewer.	
	344yds.—6in. foul sewer.	
<i>Spenborough M.B.</i>	New sewer in Hartshead area.	—
<i>Stanley U.D.</i>	To new estates.	To Smalley Bight sewage works.
<i>Stocksbridge U.D.</i>	To new estates.	—
<i>Swinton U.D.</i>	To private houses and housing estates.	—
<i>Todmorden M.B.</i>	To new housing estates.	—
<i>Wath upon Dearne U.D.</i>	To West Melton School and private development at Racecourse housing scheme.	—
<i>Wombwell U.D.</i>	New Council housing estate and new privately owned development sites.	—
<i>Worsbrough U.D.</i>	487yds.—6in. foul sewer.	—
	487yds.—6in. surface water.	

RURAL DISTRICTS:—

<i>Bowland</i>	West Bradford sewerage commenced. 1,180yds.—5in. C.I. rising main laid from proposed pumping station to sewer at Clitheroe. Short extension to 6in. sewer at Gisburn.	—
<i>Doncaster</i>	Warmsworth housing site.	Norton sewerage and sewage disposal works scheme completed.
<i>Hemsworth</i>	Housing estates in various parishes.	—
<i>Kiveton Park</i>	Extension at Todwick completed. Work commenced on new sewer at Letwell.	New sewage disposal works at North Anston completed. Work commenced on new sewage disposal works at Letwell.
<i>Nidderdale</i>	500yds. at Knapton Lane, Upper Poppleton.	New small works at Hunsingore.
<i>Osgoldcross</i>	Burton Salmon estate.	Burton Salmon estate—filter bed, humus tank and pumping station added.
<i>Penistone</i>	Works in progress at Ingbirchworth, Crane Moor and Hood Green.	New works at Hood Green.
<i>Ripon and Pateley Bridge</i>	—	New sewage disposal works at Shaw Mills.
<i>Rotherham</i>	Netherthorpe, Aston.	Reconstruction of Laughton Common pumping station.
<i>Skipton</i>	125yds.—6in. sewer at Burnsall.	—
<i>Tadcaster</i>	Great Preston housing site. Private estate (Swillington Lane).	—
<i>Thorne</i>	Hatfield and Kirton Lane, Thorne.	—
<i>Wakefield</i>	New Crofton, New Sharlston, Nether-ton.	At Haigh.
<i>Wetherby</i>	Kirkby Overblow and Thorner.	New works at Thorp Arch.
<i>Wharfedale</i>	60yds.—9in. at Bramhope.	—
	221yds.—9in. at Pool.	
	40yds.—6in.	
<i>Wortley</i>	For new developments.	Scheme prepared for extension of Wharnccliffe Side Works which are overloaded.

Private Street Works Act, 1892.—Tadcaster Rural District. Private Streets at Ledston Luck. The unsatisfactory condition of certain unmade streets in Ledston Luck and an objection by the owners were the subject of a hearing at the Castleford West Riding Magistrates' Court held on the 30th November, 1955. Evidence was given by the Deputy County Medical Officer as to the conditions constituting a menace to the health of the inhabitants. The case was decided in favour of the County Council.

Nuisance Inspection and Action.—

	Total No. of Inspections made in 1955 for nuisances only	Notices for Abatement of Nuisances						Total No. of Summonses etc.
		Informal			Statutory			
		Outstanding at 31.12.54	Issued in 1955	Abated in 1955	Outstanding at 31.12.54	Issued in 1955	Abated in 1955	
Municipal Boroughs and Urban Districts	50,204	3,375	14,984	14,700	1,011	2,915	3,057	82
Rural Districts	5,477	885	2,184	2,199	153	410	276	29
Totals	55,681	4,260	17,168	16,899	1,164	3,325	3,333	111

Swimming Baths, Pools etc.—

	<i>Public Swimming Baths or Pools</i>	<i>Privately owned Baths or Pools open to the Public</i>	<i>Paddling Pools</i>	<i>Baths for School use only</i>	<i>Private Riverside Running Pool</i>
Municipal Boroughs and Urban Districts	34	3	3	2	—
Rural Districts	1	5	—	—	1

These baths and pools receive regular supervision regarding water treatment, etc. by the County District Sanitary Inspectors, Surveyors, etc.

Prevention of Damage by Pests Act, 1949.—During the year 25 inspections were made by the County Sanitary Inspectors at school kitchens regarding rats and mice infestation. Reports on the structural conditions were forwarded to the Chief Education Officer. Disinfestation treatment was carried out by the County District Sanitary Inspectors and their staffs. The majority of inspections were carried out jointly by the County Sanitary Inspectors and the County District Inspectors.

The following table shows the action taken by the County Districts:—

	<i>Number of Inspections</i>	<i>Infestations dealt with</i>
Municipal Boroughs and Urban Districts	35,608	6,583
Rural Districts	11,901	2,897

Attention has also been given to the control of rat infestation in sewers.

Rural Water Supplies and Sewerage Acts, 1944 to 1955.—The following details show the applications for grants during the year and other action taken regarding previous applications:—

<i>Name of Authority</i>	<i>Description of Scheme</i>	<i>Date of Application</i>	<i>Estimated Cost</i>	<i>Date County Council's observations sent to Ministry</i>	<i>Remarks</i>
			£		
RURAL DISTRICTS:					
Bowland	Proposed reconstruction of Waddington Sewage Disposal Works.	6.9.55	14,500		
Goole	East Cowick Water Supply extension.	(1954)	4,086	11.5.55	
Hemsworth	Huntwick, Foulby, Nostell, Hessle, Hill Top, etc. Water Supply.	(1954)	5,670	13.4.55	
Hepton	Heptonstall Water Supply.	(1947)	19,350	9.4.47	Revised grant by Ministry 14.6.55
do.	Water Supply to Charles-town.	(1953)	14,800	3.11.53	Revised grant by Ministry 11.10.55

<i>Name of Authority</i>	<i>Description of Scheme</i>	<i>Date of Application</i>	<i>Estimated Cost</i>	<i>Date County Council's observations sent to Ministry</i>	<i>Remarks</i>
Kiveton Park	Anston Sewerage and Sewage Disposal Scheme.	(1951)	£ 32,300	6.2.52	Ministry fixed Exchequer Grant 1955
do.	Anston, etc. Water Supply.	(1953)	14,575	1.4.53	Ministry fixed revised grant 1955
do.	Water Supplies to Dinnington and Firbeck.	(1954)	4,000	6.1.55	
do.	North Anston Sewerage Scheme.		18,675		County Council Grant £8,000 1955
do.	Sewer extension Goosecar Lanc, Todwick.		6,750		County Council Grant £1,800 1955 (since reduced)
do.	Magila Cottages, North Anston, Sewerage and Sewage Disposal.		3,075		County Council Grant £800 1955
do.	Letwell Sewerage and Sewage Disposal.		10,050		Ministry fixed Exchequer Grant
Nidderdale	Killinghall, Hampsthwaite and Ripley Sewerage and Sewage Disposal.	(1952) and 12.7.55	37,000	29.5.52	Modified scheme put forward 12.7.55
do.	Water Mains Extension to Clockhill and Tancred areas—Link Main.	(1952)	4,330	5.5.53	Ministry approval 9.6.55. County Council grant fixed
do.	Copgrove Water Supply.	2.3.55	3,074		
Penistone	Sewage Disposal Works for Dunford Bridge.	(1954)	2,500	6.4.54	Ministry approval 8.3.55, £750 grant
do.	Sewerage and Sewage Disposal, Ingbirchworth.	(1954)	12,275	11.5.55	
Ripon and Pateley Bridge	Summerbridge and Dacre Water Supply. Extension to Smelthouses.	(1954)	27,602	6.1.55	
do.	Laverton Water Supply.	19.1.55	2,290	7.7.55	
do.	Skelton on Ure Sewage Disposal.	24.5.55	9,725	7.7.55	
do.	Littlethorpe Sewerage Scheme.	30.8.55	4,700		
do.	Thornton Sewerage Scheme	30.8.55	14,350		
do.	Clotherholme Sewage Disposal Scheme.	24.10.55	3,164	3.12.55	
Sedbergh	Sedbergh Sewerage Scheme and Settlebeck storm overflow drain.	1.2.55	4,179	5.10.55	
Selby	Parish of Carlton Sewerage and Sewage Disposal.	20.5.55	12,530	4.10.55	Grants approved
Settle	Water Supply, Malham, Kirkby Malham.	7.4.55	19,080	7.7.55	
do.	Proposed Surface Water Drain, Springfield, Bentham.	24.10.55	438		
Skipton	Coniston Cold and Bell Busk Water Supply.	(1954)	3,800	13.4.55	
do.	Sutton Sewerage extension to Sutton Fields.	(1954)	990	6.1.55	Ministry decline grant
do.	Cowling Water Undertaking.	8.9.55	1,785		Ministry decline grant
Tadcaster	Askham Bryan Water Supply.	(1954)	650	11.5.55	Ministry's decision 18.2.55—no grant
do.	Tadcaster Water Area.	(1954)	122,785	11.5.55	
do.	Great and Little Preston Scheme for re-drainage.	(1954)	7,990	6.1.55	

<i>Name of Authority</i>	<i>Description of Scheme</i>	<i>Date of Application</i>	<i>Estimated Cost</i>	<i>Date County Council's observations sent to Ministry</i>	<i>Remarks</i>
Tadcaster	Askham Richard Water Supply.	15.6.55	£ 1,075	4.10.55	
do.	Parish of Ledsham, Water Main Extension, Park Lane.	6.12.55	264		
do.	Copmanthorpe, Drome Estate Water Supply.	(1954)	4,141	11.5.55	Grants approved
Thorne	Sykehouse, Extension of Water Main.	26.7.55	752	4.10.55	
Wetherby	Western Arca Sewerage, Harewood, Kirkby Overblow, etc. Section Kirkby extension.	Feb. 1955	3,430	7.7.55	
do.	Parish of Harewood Water	27.7.55			
do.	Stockeld-Kirk Deighton Link Main.	9.8.55	2,770		
do.	Cowthorpe-Bickerton Link Main (Ingerthorpe Area).	18.11.55	4,290		
do.	Wothersome Water Scheme	(1951)	8,817	8.6.51	Ministry revised grant 1955
Wharfedale	Blubberhouses, Fewston and Clifton with Norwood Water Supply.	(1948)	36,917	10.9.48	Ministry decision—to pay balance of grant by half-yearly payments
URBAN DISTRICTS :					
Darton	Staincross Sewerage.	4.3.55	29,150	7.7.55	
Denby Dale	Water Supply—Scheme H.	8.4.55	62,500	4.10.55	
Ilkley	Burley Woodhead and Chevin Sewerage.	(1954)	15,025	11.5.55	
Penistone	Hoylandswaine Sewerage and Sewage Disposal Scheme No. 3.	10.2.55	18,000	8.9.55	
OTHER :					
Hemsworth Joint Water Committee	Water Supply Extensions.	1.9.55	126,690	7.12.55	

Summary of Visits and Duties carried out by the County Sanitary Inspectors.—

Inspections at dairies under The Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949-53	...	...	...	...	...	...	...	582
Number of samples of pasteurised and sterilised milk obtained	...	...	...	...	...	...	...	578
Number of samples of school milk	...	...	...	...	...	...	...	414
Visits to contractors' premises and enquiries regarding school milk	...	...	...	...	...	...	...	28
Visits to hospital farms for milk sampling purposes on behalf of the Ministry of Health	...	...	...	...	...	...	...	96
Visits regarding milk supplies at school kitchens	...	...	...	...	...	...	...	12
Visits regarding the Food and Drugs Acts, "Specified Areas"	...	...	...	...	...	...	...	420
Visits regarding water supplies	...	...	...	...	...	...	...	5
Water sampling at schools	...	...	...	...	...	...	...	32
Inspections at school kitchens regarding infestations by rats and mice	...	...	...	...	...	...	...	25
Hygiene lectures given at school kitchens	...	...	...	...	...	...	...	2
Detergent testing at school kitchens	...	...	...	...	...	...	...	5
Anthrax and swine fever investigations	...	...	...	...	...	...	...	2
Meeting Ministry of Health Inspector re Hospital Farms	...	...	...	...	...	...	...	1
Visits to County Analyst regarding water supplies	...	...	...	...	...	...	...	4
Investigations regarding pig-keeping	...	...	...	...	...	...	...	4
Magistrates' Court attendance regarding "Specified Area" offence	...	...	...	...	...	...	...	1
Investigations regarding general insanitary conditions	...	...	...	...	...	...	...	6
Visits to school swimming baths	...	...	...	...	...	...	...	2
Inspections of refuse tips	...	...	...	...	...	...	...	4

Visits regarding Pharmacy and Poisons Act	...	...	...	...	...	904
Ministry of Housing and Local Government Inquiry attended regarding sewerage scheme						1
Inspections made under the Housing (Rural Workers) Acts, 1926-42	...	...	...			256
Attendances at meetings of the West Riding of Yorkshire Regional Smoke Abatement Committee	...	...	...	...	...	5
Meetings between the County Sanitary Inspectors, Divisional Medical Officers of Health and Sanitary Inspectors of the County Districts	...	...	...	...		49

Food and Drugs Acts, 1938-50

All County Inspectors of Weights and Measures are appointed Sampling Officers for the purpose of the above Acts, and the work of sampling is carried out under the control of the Chief Inspector of Weights and Measures, Mr. J. W. Hopkinson. Details of the work carried out under the Acts are referred to in the Annual Report to the County Council of the Public Analyst, Mr. Raymond Mallinder, B.Sc., F.R.I.C., who has kindly consented to its inclusion in this Report:—

During the year, 3,958 samples were submitted for analysis by your Inspectors under the Food and Drugs Acts, 1938-1950. The main categories are divided as set out in this table:—

	<i>Total Samples</i>	<i>Adulterated or below standard</i>	<i>Percentage adulterated or below standard</i>
Milk (Appeal to Cow)	41	—	—
Milk	2,594	141	5.4
Foods and Drugs	1,323	61	4.6
All samples	3,958	202	5.1

The proportion of adulterated or substandard samples compares favourably with those of other large Authorities.

The following notes on substandard samples may be of interest:—

Butter.—Out of 12 samples, 2 contained an excessive proportion of water. This is very unusual in these days of large scale blending.

Butter Sweets.—There is an accepted Code of Practice within the trade that sweets with names incorporating the word “Butter” (as distinct from “Butter-flavoured”) shall contain at least 4 per cent. of Butter fat. Out of 16 samples analysed, 4 were unsatisfactory. in that their butter fat content was below the limit.

Buttered Teacakes.—When a “buttered teacake” is asked for in a cafe or snack bar, it is more than likely that teacake spread with margarine will be supplied. Out of 4 samples of Buttered Teacake, 3 were found to be spread with margarine. Following representations made by Food and Drugs Authorities, and some prosecutions, many proprietors display a prominent notice to the effect that they use margarine on bread, teacake and scones. At some cafes it is necessary to ask specifically for “teacake and best butter” to make sure that butter is supplied.

Foreign Bodies in Food.—It is astonishing how often “foreign bodies” are now found in food. Some are due to understandable accidents, but others are due to culpable negligence, and are potentially dangerous. 12 samples have been submitted for examination:—

7 loaves of bread, 4 of which contained machinery grease, 1 contained wood splinters, another contained a spider beetle, and another the larva of a moth.

An ice cream cornet was particularly disgusting in that it contained a cockroach.

A bottle of lemonade was tainted with paraffin.

A small bottle of vinegar had flies floating in it.

A pork pie contained a most frightening object which appeared to be a centipede or a group of spiders; this proved to be simply a piece of pig skin, complete with bristles.

A chocolate sweetmeat which contained a rusty nail.

Most of these unsatisfactory samples are brought to the notice of Inspectors by members of the public.

Ice-Cream.—The composition of Ice-Cream, as regards its sugar, fat and non-fatty-milk solids is controlled by the Food Standards (Ice-Cream) Order 1953. Of 57 samples, only 3 were found to be below standard.

Iced Lollipops.—These frozen products are made of syrup, sometimes flavoured with actual fruit juice, and water. If metal moulds are used, the acid in the syrup tends to dissolve a certain amount of metal; 8 samples were tested, and in only one case was there an excessive proportion of lead.

Labelling.—Hundreds of labels are examined annually to see whether they agree with the composition of the sample to which they apply. Only 4 labels were out of order, and these were supplied with a soft drink, throat tablets, tonic tablets and a marzipan.

Milk.—This commodity receives special attention. Out of 2,594 samples submitted, 141 were unsatisfactory, emphasizing the need for vigilant sampling. One of the worst adulterated samples contained 36.7 per cent. of added water; another contained 1.62 per cent. of fat instead of the minimum requirement of 3 per cent.

Hot Milk.—Hot Milk is bought in cafes and snack bars; one sample contained over 13 per cent. of added water.

Channel Islands Milk.—This should have at least 4 per cent. of fat. Out of 27 samples only 1 sample was below standard.

Potted Meat.—We expect Potted Meat to contain at least 70 per cent. of actual meat and to be free from breadcrumbs, rusk and other starchy filler. One sample was below standard as regards meat, and 3 others were adversely reported because they contained starch.

Preservatives.—Most foods are tested for preservatives. The Public Health (Preservatives, etc. in Food) Regulations permit the use of only two preservatives, namely Sulphur dioxide and Benzoic Acid, in strictly limited concentration and in certain specified foods. Sausages may contain up to 450 parts of Sulphur dioxide per million provided that its presence is declared. 1 sample contained 890 parts per million, and 4 other samples contained this preservative in spite of the fact that there was no notice or label declaring its presence.

Sausages.—In the absence of a legal standard for the meat content of sausages, most Public Analysts expect 50 per cent. of meat in Beef, and 65 per cent. in Pork Sausages. Some butchers think that the latter standard is too high, and prosecutions throughout the country have met with varied success. It may be that the problem will be solved by the reintroduction of a standard, or else the obligation to declare the meat content of the sausages by label or notice.

Prohibited Colouring in Food.—No prohibited food colourings were detected during the year.

Shredded Beef Suet.—This is prepared by lightly coating the shreds of Beef Fat with ground rice or flour to prevent them from sticking together. The proportion of rice or flour is controlled by the Food Standards (Suet) Order, 1952, so that the product must contain at least 83 per cent. of Beef Fat. Out of 16 samples, only 1 was below standard, containing 79 per cent. of fat.

Non-Brewed Condiment.—Is the name for what was formerly known as artificial, or Non-Brewed Vinegar. It is made of water, acetic acid, colouring and flavour, and sometimes achieves a reasonable imitation of malt vinegar in appearance and taste. 1 sample was quite unsatisfactory; it contained 10.7 per cent. of acetic acid, which is more than double the normal concentration, and was terribly sour.

Pork Dripping.—1 sample was unsatisfactory, being rancid.

Spirits.—43 samples of spirits, including gin, rum, brandy and whisky were submitted. Only one sample, a whisky, was below strength.

A scheme is in operation whereby the County Council pays the fees of the Public Analyst for all samples of milk taken by Sampling Officers of West Riding County District Councils in accordance with regulations made under the scheme, and also conducts all legal proceedings and defrays all consequential legal expenses. The number of samples of milk submitted for analysis under the scheme in 1955 was 234 of which only 4 were found to be adulterated or below standard.

PART VI

OTHER SERVICES

The Welfare of the Epileptic and Spastic

The following are the particulars of known epileptics and spastics:—

<i>Adults.</i>	<i>Number</i>	
	<i>Epileptics</i>	<i>Spastics</i>
1. Provided with accommodation under Part III of the National Assistance Act, 1948:—		
(a) in colonies for epileptics	54*	
(b) in homes for spastics		Nil†
(c) in County establishments and establishments where County Council has “right of user”	52	2

* Cookridge Hall Epileptic Home was opened in December, 1955, and the County Council was allocated 8 beds. Cases were transferred from the more distant colonies.

† Although none at present several cases have been sent for interview to the National Spastics Society’s screening panel in London and cases will be admitted in 1956.

- | | | |
|---|----|----|
| 2. Registered under the County Council’s Scheme of Welfare Services for Handicapped Persons (General Classes) | 56 | 42 |
|---|----|----|

Children.

Number ascertained as handicapped:—

(a) Attending ordinary schools	Not known	111
(b) Attending special schools	27	92
(c) Receiving home tuition	4	1
(d) Receiving no education	—	11

The register of handicapped persons, including epileptics and spastics, under the approved scheme has been kept up to date and the information recorded includes the medical classification and assessment of their suitability for employment. Again much thought has been given during the year to furthering the County Council’s approved scheme under Sections 29 and 30 of the National Assistance Act, 1948, but owing to the relatively small number of handicapped persons in any one community in the County, the setting up of craft and social centres has not developed considerably during the year. A few centres are being operated through the agency of voluntary organisations in the County Boroughs and these generally serve handicapped persons in the contiguous West Riding areas.

There are now 3 full time handicraft instructresses working in the County. From this agency over 300 handicapped persons were actively engaged in home handicraft work and of this number 25 were epileptics and 18 were spastics.

Again advice to handicapped persons on their various problems and assistance and liaison with other statutory bodies is effected through the 9 Divisional Welfare Officers.

The County Council during the year made grants to various organisations providing voluntary services for handicapped persons and during the year a grant of £25 was made to the National Spastics Society. The local branches of this Society are now operating in several districts of the West Riding. The welfare of epileptics includes the grant of £10 by the authority for an epileptic to have a holiday at Scarborough.

The question of employment of handicapped persons in open industry has been considered during the year and a Placement Officer has now been appointed. Three epileptics have been referred to the Placement Officer for help regarding suitable employment.

Certification and Treatment of Blind and Partially Sighted Persons

The following table gives particulars of new registrations during 1955 of blind and partially sighted persons (other than handicapped school children):—

(i) No. of cases registered during the year in respect of which para. 7(c) of Form B.D.8 recommends:—	Disability (B. — Blind, P.S. — Partially Sighted)									
	Cataract		Glaucoma		Retrolental Fibroplasia		Others		Total	
	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.	B.	P.S.
(a) No treatment	—	—	—	—	—	—	—	—	243	100
(b) Treatment (Medical, Surgical or Optical)	95*	50†	32	6	2	—	62	34	191	90
(ii) No. of cases at (i)(b) above which received treatment.	57‡	33§	25	4	2	—	46	22	130	59

* Includes 13 cases of cataract with glaucoma.

† " 6 " " " " " "

‡ " 9 " " " " " "

§ " 4 " " " " " "

Registration and Inspection of Disabled and Old Persons' Homes

(National Assistance Act, 1948)

The undermentioned premises, which are inspected in conjunction with officers of the Welfare Department, are registered as Disabled and Old Persons' Homes:—

	Number of Residents	Type of Home *(Part I, II, or III)
Congregation of Sisters of Charity of our Lady of Good and Perpetual Succour, St. Anne's Convent, Burghwallis	15	I
Mrs. Bessie Fox, "Moor Lane House", Moor Lane, Gomersal	10	I
Harrogate Old People's Home, 66-68 Cold Bath Road, Harrogate	36	I
Skelldale Housing Society, Ltd., Borrough House, Ripon	11	I
Ernest Aycliffe Home for Deaf and Dumb Men, Fulford Grange, Rawdon	18	II
North Regional Association for the Blind, "Oaklands", Huddersfield Road, Holmfirth	30	II
Keighley and District Institute for the Blind, 13-15 Scott Street, Keighley	12	II
Misses Mary Emily and Elizabeth North, The Woodlands, Farrar Lane, Oulton	21	I
Mrs. Evelyn Berry, 23 Ash Mount, Keighley	5	III
Methodist Homes for the Aged, "Glen Rosa", Grove Road, Ilkley	32	I
Methodist Homes for the Aged, Berwick Grange, 5 Otley Road, Harrogate	28	I

Highfield Home for the Blind, Soothill Lane, Batley	14	II
Miss Rose Seery, Mayfield, 18 Beech Grove, Harrogate	11	I
Harlow Grange Cripples' Home, Otley Road, Harrogate	19	II
Catholic Women's League, Clitherow House, 49 Valley Drive, Harrogate	16	I
Mrs. Bertha Miller, "Greylands", Forest Moor, Knaresborough	6	I
Mrs. Anna F. Schramm, "Moor Top", 43 Harlow Moor Drive, Harrogate	8	I
Mrs. I. Brearley, Haversham Court, Ben Rhydding Road, Ilkley	28	III
Miss A. Fildes and Mr. P. Lowe, "Gledhow", 23 Park Drive, Harrogate	9	I
Mrs. D. Tearse, 78 Kingsley Road, Harrogate	2	I
Gratton Home for Aged Ladies, 11 East View Terrace, Otley	14	I
Mrs. A. C. Shepley, Batley Hall, Upper Batley	6	I
Harrogate Guild of Help (Avondale Trust Ltd), "The Avondale", Cold Bath Road, Harrogate	26	I
Mrs. K. D. Clarke, "Newlands", 58 Harlow Moor Drive, Harrogate	3	I

*Part I --Homes for Old Persons.
Part II --Homes for Disabled Persons.
Part III --Homes for Old and Disabled Persons.

I am indebted to Mr. F. B. Armstrong, County Welfare Officer, for supplying most of the foregoing information in this Part of the Report.

Removal of Persons in need of Care and Attention

Where a person is suffering from a grave chronic disease, or being aged, infirm or physically incapacitated, is living in insanitary conditions and is unable to devote to himself, or herself, and is not receiving from other persons, proper care and attention, steps can be taken by the Medical Officer of Health to secure the necessary care and attention for such persons. This action is taken under the provisions of Section 47 of the National Assistance Act, 1948, or, if immediate action is necessary, under the National Assistance (Amendment) Act, 1951.

From the reports of Medical Officers of Health it is clear that these powers are used with the utmost reluctance and only as a last resort after all efforts at persuasion have failed to encourage the persons to take advantage of care and attention voluntarily in a hospital or other suitable place.

The following notes are of a typical case dealt with during the year:—

"A widow of 78 living alone was found to be incapable of keeping herself and her house in a reasonably clean condition. She had been kept under observation for over six months following information with regard to her non-payment of the rent of her house. Her son who lives in the South of England in a comfortable position had repeatedly asked her to go and live with him but she had refused to do so. She was also addicted to heavy drinking. Following a report to the District Council, application was made to the Magistrates' Court for an order under Section 47 of the National Assistance Act for her removal to Part III accommodation and this removal was carried out.

She settled down remarkably well but it was felt that if she returned home to live alone she would relapse into her former habits. Accordingly an extension of the order was obtained at the end of the statutory three months' period.

The son visited his mother and consulted with the Welfare Officers and after discussion with his mother, she agreed that her house should be closed down. She is still in the Institution where she has settled down and is at present in a reasonably satisfactory condition."

It was necessary to remove compulsorily 7 women to hospital, and 4 men and 3 women to accommodation provided under Part III of the National Assistance Act, 1948.

Medical Arrangements for County Children's Homes and Residential Nurseries

The care and treatment of the children in County Children's Homes and Residential Nurseries during times of illness is undertaken by general medical practitioners under Part IV of the National Health Service Act. Divisional Medical Officers, however, are responsible for the medical examination of children on admission and discharge; subsequent routine and special examinations; the keeping of medical records; precautions against the spread of infectious disease; hours of rest and sleep; the general supervision of health, hygiene and dietary; the staffing of residential nurseries; the preparation of half-yearly reports on the general medical standards of each home and nursery. Routine examinations are undertaken monthly in residential nurseries and every six months in children's homes, the latter being undertaken so far as is practicable during school holidays in order not to interfere with normal school attendance.

Nursery and Child-Minders Regulation Act, 1948

The closure of the County Council's day nurseries has not resulted in any increase in the number of private nurseries subject to registration under the above Act. Two applicants were registered as child-minders and at the end of the year, there were four nurseries registered for the care of one-hundred-and-fifty-nine children and five child-minders registered to care for a total of not more than twenty-two children.

It is believed that there has been an increase in child-minding of fewer than three children, which is not subject to registration, but there is no available evidence to suggest that failure to include such cases in the provision for registration has resulted in any widespread abuse. The effectiveness of introducing any system of voluntary registration is debatable as those willing to participate in such a scheme would be unlikely to neglect the care of the children.

Registration of Nursing Homes

(Public Health Act, 1936, Sections 187 —195).

It is an offence for any person to carry on a Nursing Home in the administrative county area unless registered by the County Council or otherwise exempt under the provisions of Sections 192 and 193 of the Act. Applications for registration must be accompanied by a fee of five shillings, and registration is conditional upon the West Riding Health Committee being satisfied that the applicant is a fit person, that the accommodation is adequate and is in a good state of repair and properly equipped, and that there is an adequacy of staff suitably trained for the type of nursing care being provided. County Council Bye-laws prescribe the records which must be maintained and the notification which must be made in the event of a death occurring within the establishment, and the certificate of registration prescribes the maximum number of patients which may be in the Nursing Home at any one time. After registration, the Nursing Home is subject to inspection. There is provision for applicants to appeal against the County Council's decision to refuse registration or to cancel any existing registration.

One Home was closed during the year and the number of Homes on the register on 31st December was 37 providing 37 beds for maternity and 284 beds for other cases. Forty-one visits of inspection were carried out during the year. The accompanying schedule gives brief details of the Nursing Homes in the area, adjusted to include amendments and registrations awaiting approval at the end of the year:—

Name and Address of Nursing Home	No. of Beds Registered		Types of Nursing Provided					Other Information
	Maternity	Other	General Medical	General Surgical	Obstetrics	Psychiatric	Geriatric	
Brooklands Nursing Home, Long Preston ...	3	7	—	—	Yes	—	Yes	Does not do regular midwifery, but takes occasional cases.
Sunnybank Nursing Home, Braithwaite, Keighley ...	—	6	Yes	—	—	—	—	—
The Nursing Home, Devonshire Street, Keighley ...	—	5	Yes	—	—	—	—	—
Ivy Bank Nursing Home, 162 Highfield Lane, Keighley ...	—	3	Yes	—	—	—	—	—
Thornfield Nursing Home, Micklethwaite, Nr. Bingley ...	10	1	Yes	—	Yes	—	—	—
Elmhurst Nursing Home, Hall Bank Drive, Bingley ...	—	6	—	—	—	—	Yes	—
Farfield Rest Home, 29 Farfield Road, Shipley ...	—	6	—	—	—	—	Yes	—
Jesmond Nursing Home, New Street, Farsley, Nr. Leeds ...	—	12	Yes	—	—	—	Yes	—
St. Catherine's Nursing and Rest Home, Leeds Road, Horsforth, Leeds ...	—	17	Yes	—	—	—	Yes	—
The Hawthorns Nursing Home, Outwood Lane, Horsforth, Leeds ...	—	16	Yes	Yes	—	—	Yes	Generally hospital convalescent patients.
St. Joseph's Convalescent Home, Outwood Lane, Horsforth, Leeds ...	—	16	Yes	Yes	—	—	Yes	do.
Brooklands Nursing Home, Harper Lane, Yeadon, Nr. Leeds ...	—	7	Yes	—	—	—	Yes	—
West Leigh Nursing Home, Poole-in Wharfedale, Nr. Leeds ...	—	4	—	—	—	—	Yes	—
Fairholme Nursing Home, Ilkley ...	—	14	Yes	—	—	—	Yes	—
Chevin Hall Nursing Home, Otley ...	—	24	Yes	—	—	Yes	Yes	Newly-opened and not yet fully used.
Clova Nursing Home, Clothholme Road, Ripon ...	—	15	Yes	—	—	—	—	—
Ure Lodge Nursing Home, Ure Bank Terrace, Ripon ...	—	21	Yes	—	—	—	—	—
Staffa Nursing Home, 5 Coppice Drive, Harrogate ...	3	3	—	—	Yes	—	—	—
Cavendish Nursing Home, 17 Cavendish Avenue, Harrogate ...	—	7	Yes	—	—	—	Yes	—
Cavendish Nursing Home, 7 Cavendish Avenue, Harrogate ...	—	7	Yes	—	—	—	Yes	—
Chelmsford Nursing Home, 9 Rutland Road, Harrogate ...	—	3	Yes	—	—	—	Yes	—
Alexandra Nursing Home, 7 Alexandra Road, Harrogate ...	—	8	Yes	—	—	—	Yes	—
Alderson Nursing Home, 2 Alderson Square, Harrogate ...	—	6	Yes	—	—	—	Yes	Operating Theatre, X-rays, Pathological investigations.
Duchy House Clinic, 9 Queen's Road, Harrogate ...	—	22	Yes	Yes	Yes	—	Yes	—
Templestowe Nursing Home, 8 Langcliffe Avenue, Harrogate ...	—	10	Yes	—	—	—	Yes	—
Ellerslie Nursing Home, 26 Ripon Road, Harrogate ...	—	7	Yes	—	—	—	Yes	—
Imperial Nursing Home, 29 Rutland Road, Harrogate ...	6	12	Yes	Yes	Yes	—	Yes	Operating theatre.
Nursing Home, 2 East Park Road, Harrogate ...	—	2	—	—	—	—	Yes	No further cases being accepted.
Windermere Nursing Home, 1a Westcliffe Grove, Harrogate ...	2	—	—	—	Yes	—	—	—
The Pines Nursing Home, 57 Harlow Moor Drive, Harrogate ...	—	5	Yes	—	—	—	Yes	—
Norman Lodge Nursing Home, 58 Kent Road, Harrogate ...	—	22	Yes	—	—	—	Yes	—
Beech Grove Nursing Home, 1 Beech Grove, Harrogate ...	—	8	Yes	—	—	—	Yes	—
Litchdon Nursing Home, 61 East Parade, Harrogate ...	—	8	Yes	—	—	—	Yes	—
Abbey Garth Nursing Home, 28 Abbey Road, Knaresborough ...	—	5	Yes	—	—	—	Yes	—
Benton Nursing Home, Benton Hill, Horbury ...	6	—	—	—	Yes	—	—	—
Bright's Cottage Nursing Home, St. James' Street, Heckmondwike ...	6	2	Yes	—	Yes	—	—	—
Cross Brook Nursing Home, Todmorden ...	1	7	—	—	Yes	—	—	—
Glenhaven Nursing Home, 35 Cusworth Lane, Sprotborough, Doncaster ...	—	2	Yes	—	Yes	—	Yes	—

Medical Examination of County Staff

An appointment to a superannuable post is subject to the applicant passing a medical examination. The examinations are carried out by Medical Officers on the County Council's Staff except where the successful candidate resides far outside the geographical County when arrangements are made either for examination by another Local Authority on a reciprocal basis or by a medical practitioner, the fee of 25/- in this case being paid by the County Council. In cases where the medical certificate proves inconclusive a specialist's opinion is obtained at the expense of the County Council and the findings are made available to the family doctor.

During the year 1,179 persons were medically examined as set out in the table below and of these 70 did not reach the medical standard required for admission to the Superannuation Scheme.

Examined by County Council Medical Officers	.....	.....	.....	.....	.....	.....	1,103
Examined by Medical Officers of Other Local Authorities	.....	.....	.....	.....	.....	.....	42
Examined by General Medical Practitioners (Fee of 25/- payable by County Council)	.....	.....	.....	.....	.....	.....	34

In 31 cases a specialist's opinion was obtained.

In addition 63 Special Medical Examinations were arranged at the request of employing Departments and 27 medical examinations were undertaken at the request of other Local Authorities.

Towards the end of the year concern was felt over the possibility that there may be persons employed driving County-owned vehicles who had become medically unfit to do so. It was eventually recommended to the Establishment Sub-Committee that Chauffeurs and Drivers employed in the Council's service be medically examined as to their driving fitness on return to duty in cases where the employee has been absent over a period of three months owing to illness, or in cases where the employee is considered to be accident prone. This recommendation has now been adopted.

PART VII

THE HEALTH OF THE SCHOOL CHILD

(Being the 48th Annual Report of the Principal School Medical Officer.)

Introduction

During the year 1955, the Health of the School Child has become firmly established as the major aim of the School Health Service. It is now accepted that the need to deal with the child as a whole unit is of major importance and the main preoccupation of all members of the School Health Service is to achieve such a degree of fitness in each child as to make him capable of receiving the maximum benefit from the education available to him, such education being adapted to his mental and physical condition.

There appears to be an increasing awareness, on the part of the specialist and general practitioner services, of the nature and variety of the School Medical Officer's work and the invaluable nature of this work carried out so painstakingly.

The duty of ascertaining the various categories of handicapped children constitutes a large proportion of the work carried out by the School Medical Officer. The Education Committee are, as always, most anxious to do all in their power to provide suitable education for every type of handicapped child. The Day Special Schools for Educationally Sub-normal Children opened at Shipley and Wombwell have filled a much felt want, the one disadvantage attached to them being the fact that they are designed only to cater for children from seven to twelve years. The true educationally sub-normal child can never hope to cope with the demands of an ordinary school, so that the Education Committee's plans for two all-age Day Special Schools for Educationally Sub-normal Children at Cleckheaton and Swinton will be a very great step forward in the provision for educationally sub-normal children. The boarding special schools already in existence have continued to do excellent work, often in the face of great staffing difficulties.

As in previous years, there is still considerable difficulty in placing the educationally sub-normal child in the older age range, but this may become easier in time. The spastic child, with all its possible variety of handicaps, is the most difficult of all to place.

I regret that Dr. MacTaggart, the Child Guidance Psychologist, left the services of the West Riding County Council in September, 1955. From her appointment in 1951, Dr. MacTaggart worked alone with unremitting zeal in the service of the maladjusted child, and although the child guidance team lacked a Psychiatrist and Psychiatric Social Worker, Dr. MacTaggart rendered a very great service to the maladjusted children in the West Riding.

Shortly after Dr. MacTaggart left, Dr. S. M. Leese commenced her duties as Psychiatrist in full charge of the child guidance team, and a Child Guidance Psychologist, Mr. D. G. Pickles, M.A., was appointed to fill the vacancy created by the resignation of Dr. MacTaggart. A part-time Psychiatric Social Worker has also been appointed.

In March, 1955, the County Council agreed to an increase in the establishment of School Medical Officers and Assistant County Medical Officers from 65 to 73. This is the first amendment to the establishment since 1945 and was necessary to enable the whole range of the medical officers' duties to be undertaken adequately. Increased duties since 1945 include the medical examination of staff for the purposes of superannuation; the examination of school canteen employees; immunisation against whooping cough; B.C.G. vaccination of older school children; medical examination of entrants to Training Colleges; and the introduction of a fourth routine school medical examination. Additional appointments were made during the year, but apart from these, there were few changes in the staff of medical officers.

It is disappointing to report that the speech therapy service is still understaffed. It has been the policy of the Education Committee for some years to grant awards to enable suitable students to train as speech therapists and by 1952 it was found possible to employ the then existing full establishment of ten speech therapists. After a period of full working, sufficient experience was gained to assess more accurately the needs of the service and the establishment of speech therapists was increased to thirteen in 1954. The number of speech therapists trained to replace annual losses has not, however, kept pace with the number leaving for domestic reasons, and at the end of the year seven speech therapists only were employed. Further students are under training and it is hoped that the position will improve during 1956.

In conclusion, I wish to record my appreciation of the work of Dr. Marshall, Senior Medical Officer, who has been largely responsible for the compilation of this Report; to the staff of the School Health Service; to the School Medical Officers and School Nurses for their continued interest and enthusiasm in their work in the field; to Mr. A. B. Clegg, Chief Education Officer, and other officers on the staff of the Education Department; and to the teachers for their co-operation in furthering the health interests of all school children in the West Riding.

The Medical Inspection of School Children

The number of pupils on the registers is as follows:—

	<i>Boys</i>	<i>Girls</i>	<i>Total</i>
Nursery	285	295	580
Primary (County)	68,729	64,985	133,714
Primary (Voluntary)	23,963	22,814	46,777
Secondary Modern (County)	25,632	24,149	49,781
Secondary Modern (Voluntary)	656	927	1,583
Secondary Grammar	11,832	12,228	24,060
Secondary Technical	1,210	1,024	2,234
Comprehensive	849	855	1,704
Special Schools	372	250	622
	<u>133,528</u>	<u>127,527</u>	<u>261,055</u>

87,520 periodic medical inspections and 35,296 special inspections and re-examinations were made during the year compared with 79,553 and 33,956 for the year 1954. The comparatively large increase in periodic inspections is due to the appointment of additional medical staff and the introduction of a fourth inspection.

As noted in my previous Report, the decision to examine four age groups of children attending maintained schools has been implemented throughout the County, with the exception of three areas where, as yet, it has not been possible to cope with the additional age group. The groups examined are as follows:—

- (a) on or as soon as possible after entry for the first time to a maintained school,
- (b) during the year when the age of eight years is attained,
- (c) as soon as possible after entry to a secondary school, and
- (d) during the last year of attendance at a secondary school.

The periodic examination at eight years of age is additional to the three examinations which were required prior to the issue of the School Health Service and Handicapped Pupils Regulations, 1953, and during the year 18,971 children of this age group were inspected. To all who have had practical experience of routine medical inspections, the importance of including the eight year age group is manifest. At this age so many defects become evident — defects of vision, of hearing, especially the minor defects in the auditory field, the possibility of educational sub-normality, the early signs of maladjustment, especially in boys, in addition to minor deviations from the normal in the physical field. If any of these defects are missed at this age level due to lack of a routine medical examination then by the time such defects are found at eleven years or later, it is not only too late to attempt a cure or alleviation, but the possibility of obtaining special educational treatment, if such is required, is lessened.

Routine school medical inspections have been deplored in several quarters, but although their inevitable monotony, relieved only occasionally by an exciting diagnostic “find”, is a well-known and accepted fact to all concerned with School Health, yet their value remains unimpaired. The keen School Medical Officer is ever on the alert for trivial deviations from the normal, and with so much experience of the variety amongst “normal” children, minor deviations are noted and dealt with at their inception — true preventive medicine. This facet of school health is so unobtrusive that superficial observers tend to decry the value of this branch of the School Medical Officer’s work, but that it has a very great value is known to all who have dealings with children. Not least valuable in the routine medical examination is the opportunity afforded for a joint consultation between School Medical Officer, parent, teacher, and school nurse — the quartet in whose hands lies the health and well-being of the child.

I regret that it is again necessary to make adverse comments on the lack of facilities for medical examinations in so many schools. A warm, comfortable room, free from noise, is essential to a thorough and efficient medical examination and should be available in every school. It is still necessary in some districts to hire premises outside the school in which to conduct medical examinations, due to over-crowding in the schools, and where this provision is necessary, it is difficult to hold the important consultation mentioned above.

The following tables give details of the numbers of medical inspections made in the various age groups and the numbers found to require treatment:—

Table I

Medical Inspection of Pupils attending Maintained Primary and Secondary Schools (including Special Schools)

A. PERIODIC MEDICAL INSPECTIONS

Number of Inspections in the prescribed Groups					
Entrants .....	.....	.....	.....	.....	27,109
7 to 8 year group .....	.....	.....	.....	.....	18,971
Last year primary .....	.....	.....	.....	.....	15,720
First year secondary .....	.....	.....	.....	.....	6,737
Last year secondary .....	.....	.....	.....	.....	17,346
				Total	<u>85,883</u>
Number of other Periodic Inspections .....				.....	<u>1,637</u>
Grand Total .....				.....	<u>87,520</u>

B. OTHER INSPECTIONS

Number of Special Inspections	23,370
Number of Re-Inspections	11,926
Total	35,296

C. PUPILS FOUND TO REQUIRE TREATMENT

Number of individual pupils found at Periodic Medical Inspection to require treatment (excluding Dental Diseases and Infestation with Vermin).

Group (1)	For defective vision excluding squint (2)	For any of the other conditions recorded in Table II A (3)	Total Individual Pupils (4)
Entrants	446	3,590	3,873
7 to 8 year group	921	1,787	2,569
Last year primary	916	1,514	2,341
First year secondary	396	461	829
Last year secondary	1,066	1,342	2,285
Total (prescribed groups)	3,745	8,694	11,897
Other Periodic Inspections	69	174	207
Grand Total	3,814	8,868	12,104

Table II

A. DEFECTS FOUND BY MEDICAL INSPECTION IN THE YEAR ENDED 31st DECEMBER, 1955.
Note:—All defects noted at medical inspection as requiring treatment are included in this table, whether or not this treatment was begun before the date of the inspection.

Defect or Disease (1)	Periodic Inspections		Special Inspections	
	No. of Defects		No. of Defects	
	Requiring treatment	Requiring to be kept under observation but not requiring treatment	Requiring treatment	Requiring to be kept under observation but not requiring treatment
	(2)	(3)	(4)	(5)
Skin	1,179	860	863	232
Eyes— <i>a.</i> Vision	3,814	5,546	961	2,114
<i>b.</i> Squint	665	1,007	137	307
<i>c.</i> Other	270	263	180	84
Ears— <i>a.</i> Hearing	199	662	90	176
<i>b.</i> Otitis Media	286	631	129	156
<i>c.</i> Other	271	163	110	58
Nose or Throat	1,840	4,026	487	1,291
Speech	339	624	260	242
Cervical Glands	166	1,426	53	444
Heart and Circulation	160	903	60	353
Lungs	459	1,482	210	547
Developmental— <i>a.</i> Hernia	99	240	36	49
<i>b.</i> Other	135	761	44	217
Orthopaedic— <i>a.</i> Posture	378	525	77	129
<i>b.</i> Flat Foot	917	788	217	275
<i>c.</i> Other	741	1,829	360	457
Nervous System— <i>a.</i> Epilepsy	61	141	36	64
<i>b.</i> Other	135	379	85	123
Psychological— <i>a.</i> Development	76	613	225	299
<i>b.</i> Stability	110	510	44	179
Other	1,212	645	1,508	535

B. CLASSIFICATION OF THE GENERAL CONDITION OF PUPILS INSPECTED DURING THE YEAR

Age Groups (1)	Number of Pupils Inspected (2)	A. (Good)		B. (Fair)		C. (Poor)	
		No. (3)	% of Col. 2 (4)	No. (5)	% of Col. 2 (6)	No. (7)	% of Col. 2 (8)
Entrants	27,109	14,642	54.01	12,171	44.90	296	1.09
7 to 8 year group	18,971	10,173	53.62	8,668	45.69	130	0.69
Last year primary	15,720	8,686	55.25	6,934	44.11	100	0.64
First year secondary	6,737	3,684	54.68	2,994	44.44	59	0.88
Last year secondary	17,346	9,970	57.48	7,284	41.99	92	0.53
Other Periodic Inspections	1,637	804	49.12	821	50.15	12	0.73
Total	87,520	47,959	54.80	38,872	44.41	689	0.79

Table III
Infestation with Vermin

(i) Total number of examinations in the schools by the school nurses or other authorised persons	547,369
(ii) Total number of <i>individual</i> pupils found to be infested	11,657
(iii) Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	295
(iv) Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	2

Table IV
Treatment Tables

NOTES

- (a) Treatment provided by the Authority includes all defects treated or under treatment during the year by the Authority's own staff, however brought to the Authority's notice, i.e., whether by periodic inspection, special inspection, or otherwise, during the year in question or previously.
- (b) Treatment provided otherwise than by the Authority includes all treatment known by the Authority to have been so provided, including treatment undertaken in School clinics by the Regional Hospital Board.

GROUP 1—DISEASES OF THE SKIN (EXCLUDING UNCLEANLINESS, FOR WHICH SEE TABLE III).

					Number of cases treated or under treatment during the year	
					<i>By the Authority.</i>	<i>Otherwise.</i>
Ringworm—(i) Scalp .....	.....	.....	.....	.....	15	19
(ii) Body .....	.....	.....	.....	.....	48	6
Scabies .....	.....	.....	.....	.....	57	2
Impetigo .....	.....	.....	.....	.....	1,471	98
Other Skin Diseases .....	.....	.....	.....	.....	4,438	187
Total					6,029	312

GROUP 2—EYE DISEASES, DEFECTIVE VISION AND SQUINT.

					Number of cases dealt with	
					<i>By the Authority.</i>	<i>Otherwise.</i>
External and other (excluding errors of refraction and squint) .....	.....	.....	.....	.....	1,871	691
Errors of refraction (including squint) .....	.....	.....	.....	.....	2	17,265
Total					1,873	17,956
Number of pupils for whom spectacles were—						
(a) Prescribed .....	.....	.....	.....	.....	Nil.	9,926
(b) Obtained .....	.....	.....	.....	.....	not known	not known

GROUP 3—DISEASES AND DEFECTS OF EAR, NOSE AND THROAT.

					Number of cases treated	
					<i>By the Authority.</i>	<i>Otherwise.</i>
Received operative treatment—						
(a) for diseases of the ear .....	.....	.....	.....	.....	—	43
(b) for adenoids and chronic tonsillitis .....	.....	.....	.....	.....	—	1,881
(c) for other nose and throat conditions .....	.....	.....	.....	.....	—	135
Received other forms of treatment .....	.....	.....	.....	.....	2,098	209
Total					2,098	2,268

GROUP 4—ORTHOPAEDIC AND POSTURAL DEFECTS.

(a) Number treated as in-patients in hospitals	280	
	<i>By the Authority.</i>	<i>Otherwise.</i>
(b) Number treated otherwise, e.g., in clinics or out-patient departments	1,168	258

GROUP 5—CHILD GUIDANCE TREATMENT.

Number of pupils treated at Child Guidance Clinics	Number of cases treated	
	<i>In the Authority's Child Guidance Clinics.</i>	<i>Elsewhere.</i>
	391	6

GROUP 6—SPEECH THERAPY.

Number of pupils treated by Speech Therapists	Number of cases treated	
	<i>By the Authority.</i>	<i>Otherwise.</i>
	1,418	12

GROUP 7—OTHER TREATMENT GIVEN.

	Number of cases treated	
	<i>By the Authority.</i>	<i>Otherwise.</i>
(a) Miscellaneous minor ailments	33,059	380
(b) Other—		
1. Ultra Violet Light treatment	2,631	—
2. Chiropody	643	—
Total	36,333	380

Care of the Handicapped Child

Section 34 of the Education Act, 1944, places a duty upon Local Education Authorities to ascertain those children in their areas who, by reason of disability of mind or body, require special educational treatment, and Section 33 requires Local Education Authorities to make provision for the special educational treatment recommended. In 1953, the School Health Service and Handicapped Pupils Regulations stipulated that ten categories of handicap required special educational treatment, namely, the blind, the partially sighted, the deaf, the partially deaf, the delicate, including diabetic, the educationally sub-normal, the epileptic, the maladjusted, the physically handicapped, and those with speech defects.

Since 1947, there have been established in the West Riding two boarding special schools for the delicate, four boarding special schools for the educationally sub-normal, one for deaf plus additional handicap, two boarding homes for maladjusted children, and two day special schools for junior educationally sub-normal children. The Education Committee have embarked on the building of a further two day special schools for educationally sub-normal children at Cleckheaton and Swinton and in these two schools there is to be a full age range from seven to sixteen. The Swinton School is planned to open in January, 1957.

The emphasis has now shifted from boarding to day special schools for handicapped pupils and this will meet the desires of the majority of parents. In spite of this change of view, there will always remain a percentage of children who will require boarding special school placement in preference to day. It is axiomatic to state that the majority of parents of handicapped children tend to over-protect any child with a handicap and in so doing, they are rendering a very great disservice to the child. The more independent a handicapped child is taught to be, the happier he will become and the more able to lead a normal life as he grows up.

The work of the School Medical Officer has been tremendously increased by the need to ascertain the handicapped child. Not only must all the categories of handicap be kept ever in mind, but also the many bewildering varieties which may occur under the heading of a single handicap, and where two or more distinct handicaps are present, it is often exceedingly difficult to decide which is the major disability and make a recommendation accordingly. Ascertainment of any one handicap is a severe test of knowledge and observation, to say nothing of the skill required in gaining such a child's confidence, and makes it imperative that our School Medical Officers are kept up-to-date with the latest advances in medicine and surgery. The latter may appear to be outside the scope of school health until one realises the possibilities now of cardiac and lung surgical interference.

The number of new ascertainties and re-examinations undertaken by the School Medical Officers during the year was as follows:—

<i>Category.</i>	<i>No. of Examinations.</i>
Educationally sub-normal	871
Physically handicapped	317
Delicate	245
Deaf	52
Partially deaf	14
Epileptic	34
Speech (Requiring special school)	—
Maladjusted (Requiring hostel or special school)	75
Blind	6
Partially sighted	22
Double defect	26
Total	1,662

The following table gives details of handicapped pupils and placings in special schools and hostels during the year, and particulars of the number of children in residence in special schools at the end of the year.

Category	New Ascertain-ments	New placings in Special Schools	Total No. attending Special Schools		No. Boarded in Homes or Hostels	Number Attending Independent Schools	No. awaiting placement in Special Schools	No. receiving Home Tuition
			Day	Boarding				
Blind	4	9	—	49	—	2	10	—
Partially Sighted	17	9	10	53	—	—	16	1
Deaf	16	40	28	165	—	—	12	—
Partially Deaf	3	9	7	34	—	—	3	—
Delicate	129	152	189	108	5	—	20	3
Physically Handicapped *	47	29	8	87	—	7	40	52
Educationally Sub-normal	328	127	152	315	—	7	633	1
Maladjusted	44	31	—	4	50	1	33	—
Epileptic	6	7	—	27	—	—	1	4
Totals	594	413	394	842	55	17	768	61

* Excluding children sent to or awaiting places in Hospital Schools.

The Physically Handicapped Child.—This category includes many diseases affecting the central nervous system, heart, blood, and muscles, as well as rare congenital diseases, and children who have become crippled as a result of accident or disease.

The three main groups in this category are the cases of cerebral palsy, post-poliomyelitis, and cases of heart disease. Cases of heart disease recommended for special educational treatment are steadily decreasing in number due to an increased awareness on the part of School Medical Officers of the fact that many children possessing slight abnormalities of heart sounds can, with advantage, attend an ordinary school. The more severe heart lesions are in many cases suitable for surgical intervention with a return to a normal mode of life and education.

With regard to post-poliomyelitis, many of these cases require education in either a Special School for the Physically Handicapped or in a Hospital Special School.

This leaves the children suffering from cerebral palsy as forming the largest single group of physically handicapped, and in spite of its nation-wide publicity, this problem does not appear to become any easier to solve. The fact that every case of cerebral palsy has some brain damage to a greater or lesser degree is so often lost sight of, with consequent raising and then lowering of parents' hopes, that it was a very healthy indication indeed to hear this aspect of the problem aired from the platform at the one-day Conference on Cerebral Palsy held in London in September, 1955, by the British Council for the Welfare of Spastics.

The damage done to the brain in cases of cerebral palsy can lead to a bewildering variety of defects, with never less than two, and frequently more than two, present in any one child. In addition to physical defects such as spasticity, athetosis, tremors, or ataxia, there can also occur partial or complete loss of hearing, speech, and sight, with a certain amount of intellectual impairment in addition. Some authorities, notably the Americans, maintain that seventy-five per cent. of spastics are ineducable. When one realises that the majority of the special schools in existence cater for one or at the most two defects, it can be realised how extremely difficult it is to make a recommendation for special educational treatment for a cerebral palsied child who has at least two widely differing defects. The best that one can hope for is to make a recommendation for the major disability in the hope that a school can be found which will deal with this major disability as well as fit any other defect the child may have into the school pattern. It is impossible to pigeon-hole a case of cerebral palsy into any one category of handicap.

From the foregoing, it will be evident that early diagnosis is essential. In the West Riding area many of the School Medical Officers also attend the Child Welfare Clinics, so that their knowledge of handicapped children with their need for special educational provision is available to children from infancy. This is essentially a medical problem and one in which the School Medical Officer can and does play a vital part.

The extension of toddler clinics would be a very great advance in the solution of this problem, and the establishment of pre-school clinics would help still further in the early recognition and ascertainment of cases of cerebral palsy.

There is still argument in some quarters about whether a case of cerebral palsy should be educated in a special school for spastics only, in a school for the physically handicapped, or in schools for deaf or educationally sub-normal pupils, according to the severity or nature of the 'secondary' handicap. An increasing number of schools for the physically handicapped are now admitting a proportion of cases of cerebral palsy and in the West Riding one or two cases of cerebral palsy have been admitted to a boarding school for educationally sub-normal children — in these latter cases the educational sub-normality was beyond any doubt the greater disability and the child in each case was comparatively independent physically.

Particulars relating to educable cerebral palsied children in the County are shown below. The figures include children of pre-school age and many who are not so severely handicapped as to need ascertaining officially as handicapped children.

Total No. of educable spastics	No. accommodated in Special Schools	No. attending ordinary schools		No. receiving Home Tuition	No. receiving no education
		Satisfactorily	Needing placement in Special Schools		
215	92*	67	44	1	11

*Accommodated as follows:—

Heritage Craft Schools, Chailey	6
Adela Shaw Orthopaedic Hospital, Kirbymoorside	9
Royd Edge School for Educationally Sub-normal Children	2
Holly Bank Special School, Huddersfield	18
Exhall Grange, Coventry	3
Pield Heath House Special School, Hillingdon ..	1
Braithwaite Open Air School, Keighley	1
Nortonthorpe Hall Hostel for Maladjusted Boys, Scissett	1
Bradstock Lockett Hospital School, Southport	3
Hesley Hall, Tickhill	5
Camphill Rudolf Steiner Special School, Thornbury Park	3
Wilfred Pickles' School, Tixover Grange, Duddington	2
Town Hill Park Special School, West End, Southampton ..	1
Halliwick Cripples Home, Edmonton	1
Hinwick Hall School, Wellingborough	1
St. Rose's R.C. Special School, Stroud	1
Baliol School for Educationally Sub-normal Pupils	2
St. Chad's School, Prestatyn	1
Springfield School for Educationally Sub-normal Pupils	3
Pinderfields Hospital, Wakefield	2
Etton Pasture School for Educationally Sub-normal Pupils	1
Moorlands Open Air School, Dewsbury	1
Larchfield Special School, Harrogate	1
Bethesda Home, Salford	1
National Children's Home, Chipping Norton ..	3
Brighouse Open Air School	5
Rob Roy Special School, Oakham	2
Victoria Home Special School, Bournemouth	1
Stile Open Air School, Todmorden	1
Leasowe Children's Hospital	2
Whitiness Manor, Broadstairs	2
Sheiling Curative School, Thornbury Park, Bristol	1
Welburn Hall Special School, Kirbymoorside	1
Harlow Wood Hospital, Mansfield	1
Hattondale Special School, Wellingborough	1
Wombwell Day School for Educationally Sub-normal Pupils	1
St. Margaret's School, Croydon	1

The Delicate Child.—This category consists chiefly of children suffering from bronchitis and asthma. It is becoming evident throughout the country that the number of children requiring special educational treatment in a boarding special school for delicate children is decreasing rapidly, and it makes one wonder if a change of policy would not be of benefit here. Until now it has been the policy of the West Riding Education Committee to admit children to one of its two boarding special schools for delicate children for a minimum period of six months. Apart from ascertained delicate children, there is always a number who require convalescent home treatment for a temporary period of two or three months, usually as a result of illness or because of unsatisfactory home circumstances. There is, on the other hand, a real difficulty in combining satisfactorily in one establishment the two functions of boarding school and convalescent home.

Although the number of delicate children requiring a comparatively long stay in a boarding special school is diminishing, there will always remain the hard core, chiefly asthmatics and bronchitics, who require residential provision. Despite the difficulty referred to above, consideration might be given to using the remaining places for the admission of short stay cases, say, for a term, for example, children temporarily below par in general health and who are at present sent to private convalescent homes. During the year 85 children were sent to convalescent homes for periods ranging from one to three months.

The needs of those children who require residential provision will continue to be met largely by admission to the Authority's boarding special schools at Ingleborough Hall, Clapham, and Netherside Hall, Nr. Skipton. The schools are visited periodically by Dr. Harvey, the Consultant Paediatrician, whose advice, particularly with regard to the care of the more severe asthmatic children and cases of bronchiectasis has proved most helpful.

The following is a report submitted by Dr. Hunter, the Divisional Medical Officer at Skipton, who acts as Medical Officer to the Netherside Hall School:—

"Netherside Hall School has accommodation for 40 senior boys, and has now been open for four years. During that time 103 pupils have passed through the school with an average stay of 12.3 months. This period would have been longer had not 14 boys departed on reaching school leaving age, and 16 left at their parents' request. A majority of these would have benefited by a longer stay, but there is usually a number of factors involved in these cases, and the policy has been to permit such children to leave unless there are very good reasons for opposing it. 66 boys have been discharged, having been cured or improved sufficiently to return to an ordinary school. The longest stay of any boy has been 41 months.

In these days when there are so many fine schools, and the living conditions of the bulk of the population have so greatly improved, the question is sometimes asked as to whether open-air schools are still necessary. Experience at Netherside leaves no doubt about the answer, for many of the boys are there because they have been unable to secure education in any other way, and the remainder have been admitted on the recommendation of experienced doctors after careful consideration of their physical disabilities, and their environment. Furthermore, the open-air school gives to the less healthy child the feeling of belonging to a community of his fellows. He is no longer the 'odd man out', unable to take part in the activities of the normal school, and with a feeling of inferiority because he has fallen behind in his studies by frequent absences from school. In the smaller open-air school the boy can be given individual attention, and does what he can without being pushed beyond his capabilities. These are very important factors, and it is a satisfying experience to watch a shy, timid and ailing boy develop in a friendly atmosphere where the curriculum and activities are arranged for his benefit.

In regard to the pattern of cases, there has been little change in the past year, and the asthmatics are still our major problem. Many are complicated by bronchitis and eczema. There is always a number of boys with bronchiectasis who are either unsuitable for surgical procedures, or need treatment after them; and a variety of other conditions mainly of a lesser severity and with a better prognosis.

In the last report reference was made to the need for specialist advice and treatment in a high proportion of cases, and during the year eleven boys were referred to the ear, nose and throat department of the local hospital, three receiving operative treatment. Six boys were referred to the skin specialist, four for chest X-ray, and three attended regularly for speech therapy. Two boys were admitted to hospital with appendicitis, and one with severe asthma. These are examples of the continuing need for close supervision and special treatment, and give some idea of the medical and administrative difficulties which have to be dealt with. These are in addition to the intercurrent infections, e.g., several cases of tonsillitis and six of chicken-pox during the year; and we always have a number of bed wetters.

This may seem a rather dismal record, but it should be remembered that we are dealing with forty boys each with some disease or particular difficulty, and that the period covered is one year. It might be thought that such a record would inevitably produce an atmosphere of ill-health. In practice that is not so, for a departure from usual health and activity is regarded only as an unfortunate incident which will be overcome by treatment, helped by the optimism of youth."

The Blind and Partially Sighted Child.— In this category an occasional case presents difficulty in placement due to a doubt as to the child's educability. When such a case occurs, attempts are made to assess the child's level of intelligence by the Child Guidance Psychologist and if a decision cannot be arrived at immediately, an attempt is made to find a suitable home teacher for a limited period, following which another attempt is made to assess the intelligence. Another difficulty which is occasionally encountered is the blind deaf child or the blind spastic child — it is sometimes impossible to place these in special schools. The straightforward blind or partially sighted child with normal intelligence can usually be placed in a suitable school with little delay.

The Deaf and Partially Deaf.— The number of deaf pupils requiring special educational treatment has been estimated at 0.7 to 1.0 per 1,000 registered pupils, as is indicated in Pamphlet No. 5 of the Ministry of Education on special educational treatment. At the end of the year there were 205 deaf and 44 partially deaf pupils on the register requiring placement in special schools, of whom 28 deaf and 7 partially deaf were accommodated in day special schools and 165 deaf and 34 partially deaf were placed in boarding special schools, leaving 12 deaf and 3 partially deaf children awaiting placement.

It is essential that deaf and partially deaf children should be ascertained as early as possible and here again a continuation of Infant Welfare Clinics to toddler clinics would be of inestimable value. But even in the existing Infant Welfare Clinics the clinic doctor and nurse can do much to help in the recognition of the very young deaf child. An intelligent parent should be the first to notice whether a baby is hard of hearing or not and help can then be obtained from the clinic doctor or nurse, the general practitioner, and the ear, nose and throat consultant. The first three years of life are vitally important with this particular handicap, and much is being done throughout the country generally to provide quite young children with hearing aids in the endeavour to make use of what hearing they possess to enable them to develop normal or nearly normal speech.

As mentioned in my Report for last year, a short course on the ascertainment and training of the deaf child has been arranged for School Medical Officers and a London Consultant who has done a great deal of work in this field will give two lectures, but a full account of this course will be available in the Report for 1956.

I feel that there is still a proportion of children in our schools with some degree of hearing loss who are not recognised as being hard of hearing and in some cases they may even be regarded as being educationally sub-normal. In all doubtful cases a pure tone audiogram should be obtained, and if need be this should be repeated. If such an audiogram indicates a loss of the high frequencies then the child must be given help in the form of a hearing aid.

A survey with the gramophone audiometer was undertaken in the Castleford Division during the year and the following report has been submitted by Dr. J. M. Paterson, the Divisional Medical Officer. The report appears to confirm an increasing belief that the gramophone audiometer is not an entirely satisfactory instrument for discovering children with defective hearing. What is needed is an instrument which will determine easily and quickly defective hearing, including high frequency deafness, in large groups of children. With improved instruments and development in technique, the pure-tone audiometer is now becoming widely accepted as a quick and reliable method of undertaking sweep tests of large groups of children.

"Audiometry testing has been carried out in this area using a gramophone audiometer during the past two years on school children in the age groups 8 to 11 years attending the local junior schools. All the initial testing was carried out by one of the school nurses in Castleford who had received no special instruction in the use of the gramophone audiometer and had had no previous knowledge or experience of this type of work. She had the advantage of contact with the aural surgeon of the area, Mr. Mayall, at the School Ear, Nose and Throat Clinic held in the local hospital every two weeks and so had previous knowledge of several of the children found to have defective hearing.

The size of the problem soon proved to be enormous and it was obvious that one nurse could not possibly manage to test all the children even in the limited age groups as well as cope with the marking of the papers and her normal routine school nurse's duties. Only five out of the fourteen Junior schools in Castleford have so far been visited and there are a further eight schools in Normanton. In view of this, and the fact that about 30% of the children already tested appeared to have defective hearing, it was decided to concentrate on a sample of these children, to investigate them further and try to determine which, if any, required pure-tone testing or other investigations, and treatment or special educational methods. Also, it was hoped that some assessment of the value of this method could be made so that the usefulness of this sort of investigation could be weighed against the time involved, and results of other investigations, e.g. school medicals, teachers' and parents' reports, etc.

INITIAL TESTING IN THE SCHOOLS

This was carried out by the school nurse in the schools on groups of from 10 to 20 children at a time according to the accommodation available. Although the utmost co-operation was received from the teaching staff, the accommodation available was often grossly but unavoidably unsuitable, especially in the older schools with communicating or divided classrooms and those schools situated on busy thoroughfares. It was impossible to obtain standard conditions even after making allowance for the 15 decibel background noise for which the instrument allowed, consequently the results obtained varied greatly from school to school and even in the same school with the same children on subsequent visits.

The test was carried out as advised by the makers of the instrument used. In each case, the nurse instructed the children as to what was required of them and told them what to expect to hear. A few minutes had to be allowed for the novelty of the headphones to wear off, then the test could begin. First the children were asked to write in their names, ages, date, forms and name of school at the top of their papers. We found this practice to be invaluable as immediately we had some idea of the educational status of the pupils concerned and so could review their answers accordingly. The headphones were then adjusted and the test began. It took about 20 minutes to complete, but, of course, had to be repeated if any interruptions occurred. Only three or at the most four sessions could be completed in any one morning or afternoon so that at a maximum, only 80 children could be tested or 160 in a day. In practice, many fewer children were tested per session both on account of accommodation difficulties and the fact that with only one operator, it was impossible to watch 20 children closely and continually to prevent cheating and overcome difficulties in filling in the forms.

The papers were collected and corrected after each session and any child with a hearing loss of 15 decibels or more in one or both ears was regarded as having failed the hearing test.

A second test under exactly the same conditions was then carried out on another occasion on all those children who failed the first time. The papers were corrected as before and it was after we were aware of the results of this second test that it was decided to do a small pilot survey on a few of these children as the numbers failing seemed to be so great, and out of all proportion to the number of deaf children expected to be found. A third test was, therefore, carried out at the Castleford School Clinic inviting groups of 12 children to attend at hourly intervals.

The results of 247 children taken from three Junior Mixed schools in Castleford will now be discussed as these were on children on whom the pilot survey was carried out. 95 of those who failed the first time were re-tested in school and the 36 who failed this second test were tested for the third time at the school clinic.

RESULTS

First test. Of the total 247 children aged 8 to 11 years tested in the three schools, only 152 children, i.e. 58% of them passed. Two of the schools show a similar percentage (65.7% and 67.7% respectively) but of the children of the first school tested only 43% passed. It is difficult to account for this discrepancy as the school was quieter than either of the other two. Probably it was the fact that it was the first school to be tested.

Second test. 59 children passed this second test out of the total of 95 children retested, i.e. 62.6%, but results of the three individual schools show a wide scatter. On such small numbers it is impossible to draw any definite conclusions but possible contributory causes may be that in the first school the pass list was high (50%) as the test was carried out better, the method having become more familiar and in the third school, the pass list was low (9.5%), on account of the noisy situation of the school.

Whatever the reasons, after these two tests we now found ourselves faced with the remaining 37.4% who had failed this second test. It was generally felt both by ourselves and the teachers that in the majority of these cases, causes other than deafness were at fault. If this was so, further investigations of these children were necessary including a clinical history from the parents, and school record cards, a progress report from the teacher, an examination of the children concerned, and a third estimation of the hearing by the same method but under improved circumstances. As has been already stated, it was decided to carry out this third audiometric examination at the school clinic on small groups of children — up to a maximum of 12 at a time allowing a full hour for each group. The schools attended by these children were visited and each child was discussed with the Head Teacher as regards educational attainment, intelligence and personality. Any signs of deafness, speech defect or specific reading or writing defect was discussed. An appointment was then made for the child to attend the clinic and in most cases, a parent or relative accompanied him. This enabled a medical history to be obtained regarding ear trouble, speech defects and motor and mental development which was often reinforced by information from the child's school record card including hospital and specialist reports. Each child was then examined for any abnormalities of the nose, throat or ears, such as upper respiratory infections, enlarged tonsils and adenoids, wax, perforated drums or otitis media.

Of all the 247 children tested, an average of 7.2% passed and of these tested at the clinic, 47.3% passed. The results of the individual schools again show a wide scatter. The third school had the best result (15 out of 21 of these tested passed). This may have been unduly high because of noisy conditions outside the school on the second visit. We are now left with the 6.1% of children who have failed this third test and the possible reasons for this will be discussed. It is interesting that each of the three schools gave a very similar percentage of failures (5.9, 5.6 and 6.6%) out of the total tested in each school. This supports the view that the results obtained from the first two tests were greatly influenced by environmental factors.

DISCUSSION

Out of the 247 children tested in the three schools, 15 were found to have a hearing loss of 15 decibels in one or both ears when tested under the most favourable conditions we could provide. Of these 15, three were referred to Mr. Mayall, the Ear, Nose and Throat Surgeon, i.e. 1.2% of the total child population sampled.

The reasons for the failure of the test were as follows:—

Wax	.....	5
Eustachian Catarrh	.....	1
Otitis Media	.....	4
Low I.Q. or poor concentration	.....	2
Unknown	.....	3

In all cases either the parent or teacher had suspected some impairment of hearing and in the case of the two children showing a low I.Q. and poor concentration, the cause had already been spotted by the teacher—the test merely served to exclude an associated impairment of hearing. On the other hand, there were several children who were thought to be deaf either by parents or teachers who, on testing, were found to have satisfactory hearing. Failure of the test in those cases was usually due to inattention or lack of ability to perform the test. It is only by watching the child actually do the test that a correct diagnosis can be made. Their papers are often misleading as, due to inattention or slowness to write an answer, they often miss a number and write the next number in the wrong space. This was the reason for wanting to test only small groups of children together. Although we had no such children in our particular group some of them may be incapable of co-operating even to this extent. It was felt by many of the teachers that this test in its present form was more influenced by the child's intelligence, educational status, concentrating powers and emotional make-up than by their ability to hear. The children's approach varied from the nervous child who was sick afterwards to the small boys who imagined they were space men: both did equally badly and showed improvement on retesting.

Of the three 'unknown' causes, one was referred to the Ear, Nose and Throat Surgeon and the other two showed a very small hearing loss in one ear only so that further investigation was not considered necessary.

Of the three children referred to Mr. Mayall, one had a history of bilateral otitis media and both ears were full of wax: one had no history of ear trouble and the drums appeared normal but we were unable to determine whether his failure was due to inattention or deafness: the third child was very deaf and had an active bilateral chronic otitis media. On pure-tone testing, her loss was 40 decibels in both ears. She is a bright child and is managing well in school, without a hearing aid, sitting at the front of the class. A fourth child with a history of bilateral otitis media whose mother was convinced she was deaf, was also referred for pure-tone testing although she had successfully passed the third gramophone audiometer test.

To summarise then:— We found we had discovered nothing new, all cases having been suspected previously either at home or school. Of the four of the otitis media cases, all were either under treatment or had been satisfactorily treated. None of the children were in need of any special educational treatment other than the one child who was already sitting at the front of her class. Although the number of children in this survey is small, I am of the opinion that testing school children in school by this method is not a satisfactory one. Even with testing at a school clinic, although it produced more reliable results in a shorter time, the method is by no means ideal as it involves the children travelling from their schools and requires more preliminary arrangements. We have found the whole method of testing to be cumbersome, time-consuming and not productive of any information which we could not have gained from parents, teachers or our own clinical assessments. Moreover, we feel that the method is so time consuming that it would be virtually impossible for a school nurse to test all the children even in these limited age groups and to retest the failures as we did before referring them for pure-tone audiometry. If the audiometer is to be fully used, a special operator is necessary who has no other commitments.

On the other hand, it is felt that we may be missing some cases of deafness by using this method which tends to produce a false sense of security. The two great disadvantages are (1) that the child's hearing is only tested over the normal frequency range of the human voice so that we are likely to miss a high frequency or other types of partial deafness and (2) is that it cannot be used for groups of children much below the eight year old level on account of the educational status necessary before a child can perform the test. In other words, a diagnosis of deafness is delayed for three years or more after a child enters school. It is not surprising in view of the two above disadvantages that we did not make any new discoveries. To me, the method seems a roundabout way of confirming a parent's or teacher's suspicions and at the same time, it is disquieting to feel that children who apparently satisfactorily pass the test may in fact be partially deaf."

The Epileptic Child.—The retention of the epileptic child in the ordinary school whenever possible is slowly becoming an accepted fact in the educational world, due to the adequacy of modern anti-convulsive drugs. If a child who suffers from epilepsy is having adequate sedation, so that a major fit in school hours is a rare occurrence, it is very much in the interests of this child to have him educated in an ordinary school. If he does have a seizure in school it should be regarded by teachers and fellow pupils alike as a mere episode in the child's life. In this way both the epileptic and his future fellow workers will develop the correct attitude to the problem of epilepsy and the many emotional and psychological difficulties encountered at the present time by epileptics at work should be completely dispersed.

There is still a number of epileptic children who require special educational treatment in a boarding special school and these are much more easily placed than formerly, due to the decreasing pressure on the special schools.

During 1955, 6 pupils only were newly ascertained as requiring treatment in a special school.

The Educationally Sub-normal Child.—At the end of the year, there were 1,481 educationally sub-normal children on the register, of whom 474 were in day or boarding special schools, one was receiving home tuition, and 373 had been recommended for special educational treatment in the ordinary school, or in special classes in the ordinary school, leaving 633 on the waiting list for admission to day or boarding special schools. The 1,481 children ascertained represent mainly the more severely retarded children, and it seems likely that there may be in the schools some thousands of children who could be classed as retarded due to causes other than innate educational sub-normality, such as frequent changes of school, frequent or prolonged absences from school due to ill health, and those with specific educational disabilities. This group should receive education in remedial classes, either at special centres for the purpose or in the ordinary school, and the Education Committee are endeavouring to make such provision where accommodation is available and when they can find the necessary staff. It is still unfortunate that a number of educationally sub-normal children are first recommended for special educational treatment in special schools at the age of eleven years, when the difficulty of implementing such a recommendation is enormously increased. It is impossible to give a concise reason for this delay in ascertainment—many teachers in the junior schools are most reluctant to admit that a child is educationally sub-normal thus leading to a failure to bring the child to the notice of the School Medical Officer; some School Medical Officers are reluctant to recommend boarding placement for such children; and throughout the country generally a good deal of confusion appears to exist as to the level of intelligence which requires special educational treatment, either in a special school or in a remedial class.

It is very much in the child's interest that if he is educationally sub-normal for any reason whatsoever, he should be ascertained as soon as possible, and certainly by the age of eight or nine years, so that the proper remedial measures may be instituted with the least possible delay.

The placing of junior educationally sub-normal children in boarding special schools is much easier than it was a few years ago, but the existing provision for senior educationally sub-normal children is quite inadequate. The increased day special school provision at Wombwell and Shipley caters only for the junior educationally sub-normal children, and welcome although this has been, it leaves a large number of the children in attendance at these schools completely unprovided for when they attain the age of twelve years. The programme of the Education Committee in building two through day special schools at Cleckheaton and Swinton is more than welcome but it leaves unsolved the problem of many of the senior educationally sub-normal children attending Shipley and Wombwell as well as those children in other parts of the County who, for one reason or another, are not ascertained before the age of 11 or 12 years and are then recommended for special educational treatment in a special school. A third new all-age day school planned by the Education Committee for the Castleford and Pontefract area will help to relieve the situation, as will the placement of educationally sub-normal pupils from the West Riding in schools maintained by the County Boroughs. This is in accordance with plans made by the Yorkshire Authorities for provision on a regional basis.

During the year, 84 children were reported to the Local Health Authority under Section 57(3) of the Education Act, 1944, as being ineducable, and 104 children under Section 57(5) as requiring supervision after leaving school. Those children who are reported under Section 57(3) of the Education Act are, like all handicapped children, the subject of very great care by the School Medical Officers. Not only does the examining School Medical Officer require a sound knowledge of child health, but also much experience in the evaluation of the child's potentialities, taking into account every possible factor which may influence the child's development, including ante-natal and neo-natal history, early development, particularly the age of appearance of the milestones of development, any defect of vision or hearing, in addition to the actual assessment of the child's level of intelligence. No single factor can be taken as indicative of a child's educability, but the sum total of those enumerated is necessary. Here it should be indicated that where a child has been correctly ascertained as ineducable at a particular age, and after a period of social training in an occupation centre the child has shown improvement, he can be re-examined, the intelligence re-assessed, and re-admission made to the educational world in a special school, if the improvement justifies this action.

The Maladjusted Child.—Dr. Stephanie Mary Leese was appointed as Child Psychiatrist in October, 1955, her appointment being seven-elevenths with the West Riding County Council School Health Service and four-elevenths with Leeds University. In practice Dr. Leese gives six sessions, the remainder being taken up by Dr. W. M. Burbury, Senior Lecturer in Psychiatry to Leeds University, undertaking a centre at Skipton. Mrs. J. P. Nursten was appointed as a part-time Psychiatric Social Worker at about the same time, and Mr. Dennis Greenwood Pickles appointed as a Child Guidance Psychologist will commence duties in February, 1956. Thus for the first time there will be the essential components of a child guidance team. A part-time Psychiatric Social Worker cannot hope to cope with more than a mere fraction of the work involved, but at least a start has been made and Mrs. Nursten is rendering invaluable service to Dr. Leese at the Shipley and Mirfield Child Guidance Centres.

In the South of the Riding it is hoped that very soon the Sheffield Regional Hospital Board will be in a position to appoint a Child Psychiatrist. When this appointment is made three-elevenths of the time of the Psychiatrist will be allocated to the West Riding, one whole day to the Rawmarsh Centre, and one half-day to Hooper House Hostel for Maladjusted Girls. Mr. Pickles, Child Guidance Psychologist, will work with the psychiatrist who is appointed to this area.

The following table gives details of the work undertaken at the Child Guidance Centres during the year, both prior and subsequent to the appointment of Dr. Leese:—

	Boys	Girls	Total
1. No. of new cases seen during year	107	46	153
2. No. of cases continuing attendance from previous year	151	94	245
3. Total number of cases seen during year	258	140	398
4. Total number of attendances made during the year	839	455	1,294
5. No. of cases recommended for residential treatment in a Hostel for Maladjusted Children	22	12	34
6. No. of cases referred for psychiatric opinion	10	2	12
7. No. of cases examined at the particular request of the magistrates	3	5	8
8. Types of problem for which cases were referred to Child Guidance Clinic:—			
(a) Behaviour	135	64	199
(b) Delinquency	24	8	32
(c) Nervous problems	53	48	101
(d) Incontinence	33	14	47
(e) Educational	10	5	15
(f) Cerebral Palsy	3	1	4

Children with Speech Defects.—One of the ten categories of handicapped pupils which has been enumerated in the Education Act of 1944 as requiring special educational treatment is that of children suffering from speech defect. Children who have been ascertained as requiring speech therapy form an integral part of the School Health Service and there should be the closest co-operation between the School Medical Officer and the Speech Therapist. All cases should be referred to the Speech Therapist through the School Medical Officer and no case should be discharged from therapy without a consultation between the Speech Therapist and the School Medical Officer. It should not be necessary to emphasise that all children suffering from speech defects should have an assessment done of their hearing abilities.

At the beginning of the year there were 45 speech therapy clinics in operation, but due to resignations of staff this number had fallen to 37 at the end of the year. In spite of this, the number of children awaiting treatment at the end of the year was 518 compared with 695 at the end of 1954. The following table gives details of the work undertaken at the clinics during the year:—

1. Total number of sessions held during year	3,141
2. (a) No. of cases treated during year	595
(b) No. of cases already attending for treatment from previous year	823
(c) Total No. of cases treated (a + b)	1,418
3. No. of cases awaiting treatment at end of year	518
4. No. of visits made to schools	217
5. No. of home visits	68

Analysis of Defects treated during year

	Boys	Girls	Total
1. Stammering	290	96	386
2. Defects of articulation:—			
(a) Dyslalia	390	155	545
(b) Sigmatism	85	60	145
(c) Rhinolalia, due to:—			
(i) Cleft Palate	33	18	51
(ii) Nasal Obstruction	16	10	26
(d) Dysarthria	7	8	15
3. Aphasia	2	—	2
4. Defective speech due to:—			
(i) Educational sub-normality	65	38	103
(ii) Deafness	10	4	14
5. Retarded speech development	74	28	102
6. Dysphonia	9	4	13
7. Other Defects	26	11	37

Analysis of cases discharged

No. of children discharged during year:—	Boys	Girls	Total
1. Speech normal	175	91	266
2. Speech improved	61	34	95
3. Unsuitable for treatment	9	6	15
4. Non-co-operation	53	22	75
5. Left School	15	11	26
6. Left district	31	9	40
7. Admitted to special schools	4	—	4
8. Observation	3	1	4

The School Ophthalmic Service

In the Report of the Chief Medical Officer of the Ministry of Education on the Health of the School Child for the years 1952 and 1953, it is very strongly urged that the vision of every child should be tested as soon as possible after entry to school. If the child is unable to name the letters on a Snellen test card, then an attempt should be made with one of the types of pictorial charts designed for non-readers or with the letter E test. If the school nurse has any difficulty, she should refer the case to the School Medical Officer who, in turn, may ask an ophthalmologist for his opinion. A defect in vision not detected at an early age can lead to considerable educational retardation.

In the above Report the Chief Medical Officer of the Ministry also gave some prominence to the need for more attention to be directed to the testing of school children for defective colour vision before leaving school and entering industry. This is particularly necessary in the case of boys, having regard to the many modern industries in which colour discrimination is important. Inability to discriminate accurately between colours places the colour-defective person at a serious disadvantage in his work, particularly where the safety of others is dependent upon him. A summary of various large scale surveys has indicated that as many as 8 per cent. of the male population have some degree of colour vision defect compared with only 0.4 per cent. in the female population.

It is important, therefore, that the colour vision of boys should be tested before they embark on occupations which will prove unsuitable to them. With a view to improving the existing arrangements, a talk on Defective Colour Vision was given to the School Medical Officers by Dr. T. S. Severs, one of the School ophthalmologists, and books of Ishihara colour vision tests have been supplied for use at the time of the school leaving periodic medical examination.

The work of the day to day school ophthalmic clinics has continued with little change except for a slight re-arrangement of the clinics in the south of the County. There has been no appreciable falling off in the number of children attending the clinics, as is evident from the following figures of children examined and the numbers for whom glasses were prescribed:

Year	No. of children examined (including re-examinations)	No. prescribed glasses
1948	10,755	8,113
1949	12,345	7,830
1950	12,341	7,289
1951	12,514	6,970
1952	14,974	8,941
1953	17,659	9,462
1954	17,691	9,240
1955	17,265	9,926

Medical Treatment at Hospitals and Elsewhere

As part of the Authority's arrangements under Section 48 of the Education Act, 1944, for the medical treatment of school children, the following clinics were in operation at the 31st December, 1955:—

Type of Clinic	Number	
	Provided directly by the Authority	Under arrangements with Regional Hospital Boards
Minor Ailment	186	—
Dental	36	—
Ophthalmic	—	65
Speech Therapy	37	—
Orthopaedic Treatment Centres	17	—
Ultra Violet Light	49	—
Paediatric	5	12
Chiropody	3	—
Consultant E.N.T.	—	17
Consultant Orthopaedic	—	18
Consultant Dermatology	—	1
Consultant Cardiac	—	1

A detailed list of the various clinics showing the days and times open is given in Appendix I.

Consultant E.N.T. Service

1. No. of sessions held during the year .....	.....	312	
2. No. of individual children seen by consultant, including those continuing attendance from previous year	<i>Pre-school Children.</i> 172	<i>School Children.</i> 2,061	<i>Total.</i> 2,233
3. No. of (2) above referred for operative treatment	131	1,221	1,352
4. No. of children—			
(a) who obtained operative treatment during the year	87	1,020	1,107
(b) treated at school clinics	4	373	377

Consultant Orthopaedic Service

A. CONSULTANT CLINICS.			
1. No. of sessions held during the year		197	
2. No. of individual patients seen by consultant, including those continuing attendance from previous year	391	1,138	1,529
3. No. of (2) above—			
(a) referred for operative treatment as short-stay cases only	12	78	90
(b) recommended long-stay hospital school	1	7	8
(c) recommended treatment by orthopaedic nurse or physiotherapist—			
(i) at treatment centres	30	179	209
(ii) domiciliary	9	14	23
4. No. of children who obtained operative treatment during the year	7	80	87
5. Total number of attendances at consultant clinic	627	1,692	2,319
B. TREATMENT CENTRES.			
1. No. of sessions held during the year		1,633	
2. Total No. of patients treated (including cases continuing treatment from previous year)	138	987	1,125
3. Total number of attendances	1,519	11,177	12,696
C. DOMICILIARY TREATMENT.			
1. Total number treated	1	—	1
2. Total number of visits to patients' homes	555	792	1,347
D. APPLIANCES.			
No. of appliances—			
(a) recommended	89	126	215
(b) obtained	36	122	158

Paediatric Service

CONSULTANT CLINICS.			
1. No. of sessions held during the year		199	
2. No. of individual patients seen			
(a) New cases	113	306	419
(b) Cases attending from previous year	75	438	513
3. Total number of attendances at clinics	188	744	932

The following table gives details of the various types of defect or disease for which children were referred for consultant opinion:—

<i>Defect or Disease.</i>	<i>Pre-school Children.</i>	<i>School Children.</i>	<i>Total.</i>
Central Nervous System	12	43	55
Heart and Circulatory System	25	175	200
Respiratory System including E.N.T. Defects	21	104	125
Speech	7	8	15
Orthopaedic	5	8	13
Skin	2	4	6
Psychological	13	32	45
Mental Defect, including educational sub-normality	14	21	35
Congenital Deformities	7	5	12
Gastro-intestinal System	12	19	31
Epilepsy	3	39	42
Genito-urinary System	1	5	6
Glands	—	13	13
Nutritional	6	42	48
Developmental	28	27	55
Muscular Disease	3	3	6
Rheumatism	—	5	5
Habit Spasms	3	8	11
Incontinence	3	125	128
Migraine	1	32	33
Unclassified	22	26	48
	188	744	932

Ultra Violet Light Treatment

At the end of the year there were 49 ultra violet light clinics in operation and the following are particulars of the children treated:—

No. of sessions held		3,260	
	<i>Pre-school Children.</i>	<i>School Children.</i>	<i>Total</i>
No. of children treated during year	1,274	2,018	3,292
Total No. of attendances	19,803	25,834	45,637

School Nursing

School nursing duties are combined with health visiting in most areas.

Attendance at medical inspection and routine hygiene inspections occupy roughly 50 per cent. of the health visitor's time. Minor ailment clinics and sunlight clinics have diminished, and some of this time has now been allotted to special clinics, for example, follow-up of medical inspections by the School Medical Officer and specialist clinics for the treatment of eyes, ears, and orthopaedic conditions.

There is a great improvement in the hygiene of the school child, and the need for special requests for clothing has become gradually less. Compared with this, however, the number of infestations, especially amongst the female school population is discouraging. The craze of the girls from nine years onwards who are allowed to have "perms" is a deterrent to personal cleanliness, but as the hair style vogue is now moving towards the "urchin cut" the prospects are brighter.

It has not been possible to ease off on the routine cleanliness inspections up to the present time, a disappointing thought when the physical health and the clothing of the school child has improved so much.

Reports by school nurses of fatigue in the classrooms raised another issue. The nurses are often requested by the teacher to examine a child's eyesight, who shows signs of strain in reading and writing; however, it is rare to find definite defects and it is felt that televiewing, perhaps late at night, is the cause.

There has been marked progress in the health education of the school child. Many nurses have now, in co-operation with the teachers, a definite scheme whereby a course of talks on cleanliness and hygiene are given at stated times during the year. The 'C' stream or the backward group has received special attention in some areas. It is found in these instances the talks, in order to be of any value, must be illustrated by a short film, strips, or gaily coloured posters, the latter designed by the nurses themselves, using local captions to arouse and maintain interest.

Diphtheria Immunisation

Particulars relating to the numbers of school children immunised during the year and the immunisation state of the population of children of school age will be found in the section of the Report dealing with Epidemiology. The schools have continued to play their essential role in furthering this valuable work and our thanks are again due to all teachers for their collaboration.

Cleanliness

The following figures show the number of children found to be infested during the year compared with previous years.

Year	Total number of examinations made by school nurses	No. of individual children found to be infested	% of school population
1947	368,370	24,862	11.3
1948	560,631	27,361	12.4
1949	574,968	23,457	10.5
1950	523,473	20,214	8.8
1951	559,388	18,599	7.9
1952	610,201	19,772	8.1
1953	575,645	17,815	7.1
1954	549,961	13,619	5.3
1955	547,369	11,657	4.5

The figures show a further improvement during 1955 and the number of children found to be infested is less than half that for 1947, an improvement being shown each year with the exception of 1952 when there was a slight increase. Credit for this gradual, though real, improvement must go to the school nurses who spend much time and effort in examining children in the schools, advising parents on treatment, following-up difficult cases, and in some cases undertaking actual treatment themselves. The figure of 11,657, however, is still too high and there are no grounds for complacency. Infestation is a condition which can be easily remedied today with the available choice of a number of effective insecticides.

Nutrition

Figures of the general physical condition of children examined at periodic medical inspections are given below for 1955 with a comparison for previous years. It will be noted that the percentage of children in the "Poor" category continues to show a decrease, and that there is a slight increase in the percentage in the "Good" category at the expense of the "Fair" (satisfactory) group.

Year	Total number of pupils inspected	Classification					
		A (Good)		B (Fair)		C (Poor)	
		No.	% of Col. 2	No.	% of Col. 2	No.	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1947	50,277	19,497	38.8	28,343	56.4	2,437	4.8
1948	71,858	26,077	36.3	41,876	58.3	3,905	5.4
1949	64,998	23,467	36.1	39,335	60.5	2,196	3.4
1950	61,977	26,820	43.3	33,528	54.1	1,629	2.6
1951	64,676	29,452	45.5	33,598	51.9	1,626	2.5
1952	62,156	30,506	49.1	30,635	49.3	1,015	1.6
1953	77,803	35,861	46.1	40,772	52.4	1,170	1.5
1954	79,553	40,315	50.7	38,344	48.2	894	1.1
1955	87,520	47,959	54.8	38,872	44.4	689	0.8

The number of meals provided to school children daily according to a check made in October, 1955, was 127,530 compared with 117,910 in October, 1954. This represents 52.5 per cent. of children on the registers.

Medical Examination of Entrants to Training Colleges

In connection with their applications for entry to Training Colleges, 952 students were medically examined during the year compared with 886 for the year 1954 and 766 for the year 1953.

Children and Young Persons Act, 1933 Employment of Children

Under the Authority's bye-laws relating to the employment of school children, 1,639 children were examined during the year by the School Medical Officers to determine their fitness for employment. The figure includes children taking part in entertainments. 11 cases only were found unfit.

Youth Employment Service

There is close liaison between the officers in the School Health Service and those in the Youth Employment Service. The Youth Employment Officers visit schools to discuss with teachers and parents the type and suitability of occupations of those children about to leave school.

Prior to this the leavers will have received their final routine medical inspection and the School Medical Officer will have informed the Youth Employment Officer of those children who are handicapped in such a way that their choice of occupation is limited.

After the handicapped child enters employment, the services of the School Medical Officer are still available to advise the Youth Employment Officer if any difficulty is encountered either regarding the actual occupation or from the point of view of the employer.

The change from school life to a working life in industry is a period of major re-adjustment and it is only to be expected that many children, particularly the handicapped, will experience difficulties which need to be carefully considered. Contrary to what might be expected, educationally sub-normal children do not generally present any difficulty. They appear to settle down easily into manual forms of employment and many go on to attend evening classes or become apprentices to definite trades.

On the other hand, the epileptic is difficult to place and keep in employment and it is important that there should be close liaison between everyone concerned. Often the School Medical Officer can advise and, if necessary, take up direct with the family doctor the necessity for adequate drug sedation to prevent as far as possible epileptic attacks occurring at work. The need for enlisting a sympathetic attitude on the part of the employer and fellow-workers is one which can best be met by the Youth Employment Officer and the School Medical Officer acting jointly.

The maladjusted child proves to be the most difficult to keep in employment for any length of time. Many of them are, without doubt, social misfits, and it is improbable that there is any ready-made solution to the problem.

Protection of School Children against Tuberculosis

Tuberculin Testing of Entrants.—The Report for 1954 included an account by Dr. R. S. Hynd, Divisional Medical Officer, of a partial survey undertaken in his area. The survey was extended in 1955 to the whole of the Division and the following report has been submitted by Dr. Hynd:—

TABLE I

District	No. of children offered Tuberculin	No. of parents accepting	No. of Positive results	% acceptance	% Positive	No. referred to Chest Physician
<i>Wombwell U.D.</i>						
Total	513	396	11	77.2	2.75	11
Total less known contacts	513	396	11	77.2	2.75	11
<i>Worsbrough U.D.</i>						
Total	330	280	9	84.8	3.2	4
Total less known contacts	325	275	4	84.6	1.4	4
<i>Darfield U.D.</i>						
Total	140	126	7	90.0	5.5	4
Total less known contacts	137	123	4	89.8	3.2	4
<i>Dodworth U.D.</i>						
Total	93	76	8	81.7	10.5	7
Total less known contacts	92	75	7	81.5	9.3	7
<i>Cudworth U.D.</i>						
Total	157	147	6	93.6	4.0	3
Total less known contacts	154	144	3	93.5	2.1	3
<i>Darton U.D.</i>						
Total	300	225	7	75.0	3.1	6
Total less known contacts	299	224	6	74.9	2.6	6
<i>Royston U.D.</i>						
Total	160	141	6	88.1	4.2	6
Total less known contacts	160	141	6	88.1	4.2	6

It will be appreciated that these surveys are conducted in association with the school medical inspection programme, which is arranged according to the school year. It is, therefore, inevitable that some schools will be included twice in the calendar year. This does not mean that the same children are included in the survey twice, as only the new entrants are examined.

During the course of this survey many children were found to be positive reactors who were already known contacts of cases of tuberculosis, and who were already attending the Chest Physician for observation. These children represent the difference between the number of positive results (Column 3) and the number referred to Chest Physician (Column 6). A further line has been added, under the totals for each Urban District, excluding these children from the survey and representing the number of new positive reactors discovered. This still leaves the Dodworth Urban District with a percentage much higher than all other districts. It was thought that this might be due to a higher prevalence of the disease there and an investigation was made into the attack rate in the seven Urban Districts over the last 5 years. The results are shown in Table II, together with the proportion of each population who were on the tuberculosis register at 31st December, 1954.

TABLE II

District	% of positive tests	% of positive tests excluding contacts	Attack Rate per 100,000 over 5 years			% of Population on Register at Dec. 1954
			Total	Pulmonary	Non-Pulmonary	
Dodworth	10.5	9.3	98.6	93.9	4.7	0.64
Darfield	5.5	3.2	143.2	127.3	15.9	0.95
Royston	4.2	4.2	140.3	103.4	36.9	0.52
Cudworth	4.0	2.1	105.0	95.9	9.1	0.58
Worsbrough	3.2	1.4	99.8	84.3	15.5	0.52
Darton	3.1	2.6	91.0	77.0	14.0	0.51
Wombwell	2.75	2.75	144.9	115.0	29.9	0.81
Divisional Totals	3.8	2.9	119.6	100.9	18.7	0.64

This research does not produce much correlation with the survey, especially in respect of the Dodworth Urban District. It will be noticed that there is poor correlation too in respect of the Wombwell Urban District, but this might be accounted for by a poor acceptance rate in two schools, one of which might be expected to be in an area of high incidence. This, however, is a matter of speculation and cannot easily be proved. When the results obtained from this survey are reviewed, in association with the tuberculin testing of 13-year-old children for the B.C.G. vaccination scheme, it can be seen that quite a marked degree of correlation is obtained suggesting that the incidence of a high percentage in Dodworth is significant as seen in Table III.

TABLE III

District	B.C.G. Scheme		Tuberculin Entrants Scheme	
	% Acceptance	% Positive	% Acceptance	% Positive
Dodworth	98.0	40	81.7	10.5
Darfield	99.0	35	90	5.5
Royston	79	23.5	88.1	4.2
Cudworth	89	30	93.6	4.0
Worsbrough	88	20	84.8	3.2
Darton	87	30.5	75.0	3.1
Wombwell	81	26.5	77.2	2.75
Divisional	85	29.4	82.3	3.8

The next matter to be considered was whether the milk supply was a factor in this discrepancy. An order was made by the Minister in April, 1953, under Section 23 of Milk and Dairies Artificial Cream Act, 1950, making these Urban Districts specified areas under the Act. The children in this survey were mostly born in 1950. It may be assumed that very little raw milk is consumed in the first year of life, but this still means that these children could have been exposed to tuberculous raw milk during two years of their life. A check was made of samples of milk found to be tuberculous over the last 5 years, but again Dodworth Urban District was not outstanding. It will be interesting to see if the percentage of positive reactors diminishes over the next two years, because this will give some guide as to whether milk has been a major factor. Failing this, it must be assumed that this small community contains some undiagnosed foci of infection.

The whole survey was carried out with the generous co-operation of the Chest Physician. At the end of the year, only two families had failed to co-operate in submitting themselves for clinical and radiological examination at the chest clinic. These families have since agreed to attend. Despite this co-operation and the high acceptance rate for the test, it is surprising that no adult cases were discovered, especially in view of the American results in this type of survey. Several adults were advised, by the Chest Physician, to attend the Pneumoconiosis Board, but otherwise the results in terms of contact-tracing were poor. Nevertheless, I feel this is a worth-while procedure and that it should be continued because the factor of infection by milk will soon be removed, and in two years time this type of survey should give some direct correlation with active foci of infection. It must be noted, however, that in some districts (e.g. Worsbrough), the known contacts of active tuberculosis accounted for a large proportion of the positive reactors. Throughout the survey contact with general practitioners has been maintained, and they have been kept informed of radiological and other findings through this office."

B.C.G. Vaccination of Older School Children.—Particulars of the Authority's scheme for the B.C.G. vaccination of thirteen-year-old children and of the number of children dealt with during 1955 will be found in that part of the Report dealing with Section 28 of the National Health Service Act, 1946 — Care and After Care, Prevention of Illness, etc.

The Work of a Children's Specialist in the School Health Service

The following notes relating to school children are taken from a report on the year's work submitted by Dr. Harvey, Paediatrician:—

Ideas and the Power of Words

One of our tasks is to get parents and others who are interested in children to see matters of health in a normal way. Much of our time at consultations, and doubtless also at school medical inspections, is absorbed educatively in trying to correct wrong concepts and attitudes. The sting has to be drawn from special fears which parents harbour in their minds, or, as Oliver Wendell Holmes would have said, ideas need to be depolarised by stripping them of their magnetic imaginative force. There is Biblical authority for the view that as a man thinks in his heart, so is he; and I believe we could do much as a profession by scrapping meretricious terminology which alarms the patient. When doctors use the word "bronchitis", a mother cannot avoid picture-thinking of disabled pensioners. She would surely not think worse of us if we called it simply a wheeze. "Catarrh" is another misused Greek word which many parents take to mean nose-block, instead of nose-drip. Most reprehensible of all is our glib use of the word "tonsillitis", when all we really mean is a sore throat. Tonsillitis is bound to make parents think in terms of tonsillectomy. It seems to me most unfair to blame these luckless forthcoming organs for a general inflammation of the pharynx and whole respiratory tract. Recent work suggests that a majority

of children on tonsil waiting lists can be kept reasonably free from sore throats and far more regular at school with small daily doses of prophylactic sulphonamides, used in the same way as for prophylaxis of rheumatic fever (Burke, J.B., 1956. *Brit. Med. J.* i. 538). This novelty could well stave off the threat of tonsillectomy for many youngsters through those couple of years in the Infant School when infections are common, so that when they reach the Junior School the indications obviously no longer apply. I am a devout believer in the value of adenoidectomy for its appropriate indications mainly in the middle ear. But I think the time is near when the random harvest of children's tonsils will be as much a matter for contrition as the harvest of infant forcskins used to be. Tonsillectomy qua tonsils may become well-nigh as unrespectable as nephropexy for back-ache, which I remember in student days. I am glad that my work lies in the sphere of influence of Sheffield, which has a very low tonsillectomy rate for school children, with little more than one-tenth the rate of a rival city. These discrepancies all over the country can be taken to reflect wide divergence of judgment, either on the part of referring medical officers or of surgeons to whom they are referred. Before leaving this theme, it may be worth pointing out recent work which shows that malted vitamins and sun-ray treatment do not prevent colds (*Brit. Med. J.*, 1956. i. 184).

Asthma

This is another word which is, I think, used freely by doctors without realising how much some parents dread the lifelong invalidism and handicap which it suggests to them. It is a word I seldom use when talking about younger children, notwithstanding that asthmatic bronchial spasm is a very common component of respiratory infections even from babyhood, and also as a separate entity in its own right. So many youngsters outgrow their tendency to bronchial spasm that the alarm suggested by the word asthma need never in their case be raised.

In school life we still have the vicious circle of interdependent bottle-necks, in which the children who most need physiotherapy and breathing exercises and out-door fresh air and the regular discipline of school life for their asthma are the children who stick it least. They are coddled indoors or in bed, and through losing so much education their emotional tension is increased through fear of return to lessons. The residential school is unfortunately our only means of breaking the sequence, and only so long as these children are kept artificially away from their homes.

"Delicate"

This is another word whose meaning has, since the War, shrunk to manageable proportions. Conventionally, it may still serve for children suffering from emotional wear and tear, and for a broad group of respiratory allergy. Wherever open-air day schools exist, there will be pressure to keep all places filled, even on meagre medical indications.

Relics of the Past

Two things irritate me at clinical examinations, the medicated coloured cotton wool fleeces pinned by grandmothers beneath children's vests, and the unhygienic rigid garments known as liberty bodices, which appear even on school boys, the rationale of which must surely have gone out with schoolgirls' long stockings. Mothers never know why they buy these objects instead of simple free-stretching vests.

Nightmares

In my own family I am accustomed to nightmares, restlessness and occasional shouting in dreams, so that I deplore the unnatural worry parents display when these things happen to their children. Even sleep-walking, in moderation, is not a matter for serious disquiet. These are the price to pay for the enjoyment of television thrillers. All too often it turns out that in these homes the bedroom light, or at least the landing light, remains on throughout the night, and parents are tricked into spending hours lying down beside the children.

Child Guidance

It is good to realize that we now have access for consultation at least with our County team, although in South Yorkshire psychiatric treatment must yet be deferred. Where does paediatric child guidance end and psychiatric child guidance begin? It is easy, for instance, to take narrow departmental views of bed-wetting as if all bed-wetters were psychiatric or urological problems. If only the guidance of all enuretics were as lucky as my advice to one mother to stop giving her child cocoa at night, which cured also the 17-year-old sister's bed-wetting! The only treatment needed for another 6-year-old bed-wetter was to stop pinning napkins on him at bedtime.

Headaches during School Life

A number of school medical officers seem to refer headaches automatically in the first instance to ophthalmologists, as if the most likely cause of headache in school children were some refractive error. These youngsters then come back to me with the ophthalmologist's normal findings. It seems a pity to make two consultations where one would suffice. I believe that only seldom will eye-strain prove to be the cause of children's headaches, and that wherever simple visual testing at school gives a roughly normal acuity in both eyes, it would be preferable to take opinion along medical rather than ophthalmological lines in the first instance. Migraine is, in fact, a common condition and may often be suggested by associated pallor, malaise, nausea or a parental history of classical migraine. This year I have three hemianopic migraines, and two which had been unlucky enough to suffer appendicectomy at the hands of locum surgical registrars. Twice I have recorded three new migraine cases in one morning.

Stomach Ache

Stomach Ache has this year become the commonest ailment referred for consultation. It is tantalizing in most cases to find no definite clues either to diagnosis or treatment. Reassurance works by a process of exclusion: a few round-worm are found, and numerous migraines, starch fermentation may be suspected, and protein allergy may be missed. Rarely a peptic ulcer will force itself upon our reluctant consciousness. But the majority remain stomach-ache, unexplained till they clear up.

Diabetes

This is in my experience still a rare condition in childhood, but we have two toddlers, as well as two new infant scholars recently diagnosed. The point is that infant school teachers will need to be asked to accept the oversight of these youngsters and to watch for possible insulin reactions, without imposing on the children the strain of being stigmatized as different from the rest.

Illustrative Short Cases

A bright boy in his "scholarship" examination term was kept off school a whole month for a simple faint during a cold with blood-stained nose discharge.

"One of my neighbours asked me if I didn't think she would be better at the Open-Air School". A second-only sheltered child of an elderly mother, healthy but hapless.

Glands in the neck: only twice in eight years has one of these cases proved to be Hodgkin's Disease. Tubercle is now almost as rare.

Simple "Habit Spasm" (head-jerking tic) treated elsewhere in bed for 9 months as chorea and subsequently sent to an Open-Air School.

What to do after leaving college with a patent ductus which is unwilling to be ligated? Despite active sport and swimming, it cannot secure superannuation. But there is the Disabled Register to fall back on.

THE SCHOOL DENTAL SERVICE

The following is the Report of the Principal School Dental Officer and Orthodontic Consultant, Mr. B. R. Townend, F.D.S., R.C.S.(Eng.), L.D.S.(Liv.), Dip. Orth. R.C.S.:—

It is with monotonous regularity that I have to report from year to year little change in the greatest hindrance to progress in the dental service of the County — shortage of staff. During the year under review we have recruited 4 whole-time officers.

The progress we have made in the establishment of clinics during the post-war years has continued and this year we have opened clinics at Morley, Bingley, Maltby, and Penistone.

The two Oral Hygienists appointed last year have done very good work at Wakefield, Brighouse, and Castleford. In addition to the actual scaling and cleaning of teeth, as shown below, they have instructed patients in oral hygiene and it is felt that their services are well worth while and form a valuable addition to the general scheme.

Children treated	1,000
No. of attendances	1,450

Dental Inspection and Treatment Carried out During the Year

1. Number of pupils inspected by the Authority's Dental Officers:—

(a) Periodic age groups	100,192
(b) Specials	8,652
Total (1)	108,754

2. Number found to require treatment	79,842
3. Number referred for treatment	68,155
4. Number actually treated	54,375
5. Attendances made by pupils for treatment	108,088
6. Half-days devoted to:	
Inspection	1,004
Treatment	16,442
Total (6)	17,446

7. Fillings:

Permanent Teeth	61,916
Temporary Teeth	4,017
Total (7)	65,933

8. Number of teeth filled :									
Permanent Teeth	.....	.....	.....	..	.....	..	.....	.....	53,556
Temporary Teeth	.....	.....	.....	.....	...	.....	.....	.....	3,682
Total (8)									57,238
9. Extractions :									
Permanent Teeth	.....	..	...	.	.....	...	.....	.....	17,014
Temporary Teeth	.....	.....	.....	.....	.....	.....	.....	.....	71,852
Total (9)									88,866
10. Administration of general anaesthetics for extractions									22,382
11. Other operations :									
Permanent Teeth	.....	.....	.....	.....	.....	.....	.....	.....	28,266
Temporary Teeth	.....	.....	.....	.....	.....	.....	.....	.....	3,410
Total (11)									31,676

Analysis of the Work carried out during the Year.—The information concerning dental treatment provided for school children in the above table gives a very limited picture of the actual work done and the following implementations and refinements to the table may be of interest.

The total of 71,852 temporary teeth and 17,014 permanent teeth extracted does not represent, as might be thought, so many teeth which it has been found impossible to save. No less than 10,179 temporary teeth and 2,390 permanent teeth have been extracted with a view to making room for the other teeth or to ensure in various ways that succeeding teeth shall grow in regular order. Approximately 1 tooth in 7 is extracted with the object of preventing irregularity and ensuring the satisfactory future of the dentition.

3,682 temporary teeth were conserved by the following means:—1,995 cement fillings, 585 amalgam fillings, 1,437 combined cement and amalgam fillings. 32,825 first permanent molars and 20,731 other teeth, a total of 53,556 permanent teeth were conserved by the following means:—1,084 cement fillings, 11,119 amalgam fillings, 44,125 combined cement and amalgam fillings, 5,588 silicate (porcelain) fillings. Other treatments of a varied nature include 164 root fillings, 4,931 dressings, 144 crowns, inlays, etc., 4,409 scalings and gum treatments. Dentures were provided in 399 cases to replace teeth lost by accident or disease, 1,359 attendances being made for the necessary work incurred in the fitting of these dentures.

The very large figure of 31,676 other operations which appears in the Table merits some explanation. It represents an omnibus classification of all cases which receive dental attention of various kinds other than those falling into the categories specifically mentioned.

It includes such things as 12,470 attendances for orthodontic treatment, 1,359 attendances for prosthetic treatment, 4,409 scalings and gum treatments, 1,570 X-rays, 4,931 dressings, etc.

The intelligent and scientific practice of dentistry has now passed the stage when it is solely concerned with the relief of pain, the filling of teeth and the restoration by means of dentures, of the natural teeth when they have been lost through disease. We are beginning to look upon the teeth as part of the human body which must be studied and cared for in relation to the body as a whole and not as an isolated unit. Perhaps in no field of dentistry has this concept been realised more than in the study and practice of orthodontics. Some of the unfortunate children we have to deal with possess mouths in which the teeth are so irregular as to be a travesty of normality, a source of ridicule and hopelessly inadequate and inefficient in performing the function of mastication. More especially does one find these conditions in that branch of orthodontics which is concerned with the study of the teeth and jaws in relation to certain very common habits of childhood. Perhaps the most common of these habits is finger or thumb-sucking.

This habit which in the very young child is often regarded as something rather engaging and attractive can, if persisted in, produce very gross and disfiguring irregularities of the teeth. Why it should persist, even into adult age in some cases, is rather puzzling but the extensive researches which we have been undertaking in the West Riding during the past few years suggest that thumb and finger sucking is not so much a bad habit which has been acquired like nail biting, but is rather a persistence of an infantile pattern of behaviour. The young infant has to suck in order to live. It is as important as the beating of its heart and the filling and emptying of its lungs. When, however, it reaches a certain age it ceases to obtain its food by suction and commences to eat in the adult fashion. In some cases it would seem that the primitive urge to suck does not disappear at the appropriate time, but persists. The child does not grow up or mature in this particular stage. It does not start to suck, it never stops and it may never surmount this particular hurdle of growing up.

We have found that in the vast proportion of cases the cure is quite simple and effective. We talk to the child and usually find that it wants to stop sucking its thumb or fingers but it just cannot remember. It does it unconsciously when concentrating or going to sleep. We then make a small plate which the child wears night and day and which we call a "reminder plate". It is to remind the child not to suck its thumb. It is also likely that the plate renders the practice of sucking less pleasurable but, of course, we do not tell the child that! We have met the odd cases where the habit seems to be a mechanism to counteract mental conflicts and insecurities in the child's life. These cases usually manifest themselves quite early in the treatment — the child is resentful or breaks the appliance. We realise that these cases, which are few and far between, are outside the range of help we can give them and we have to abandon our particular line of treatment. It would seem that the treatment of such cases falls within the realm of the psychiatrist or psychologist.

There is an interesting sideline to this work we are doing which has confirmed our view that sucking habits are fixations at an earlier level of maturation. We have had quite a number of cases who, when they stopped sucking their thumbs or fingers, shot ahead in their scholastic work and in one dramatic case a boy went from the bottom to the top of his form in twelve months. In other cases persistent bed-wetters have ceased to do so as they stopped the sucking habits. There may be some element of coincidence in these happenings, but they are so numerous as to suggest at least that by helping the child over one hurdle of the process of growing up we have helped him over others.

We feel very pleased that in this we are making some contribution to the development of the fullness of mature enjoyment of life to some of the children under our care.

Keighley Excepted District

The following report on the year's work is submitted by Dr. H. M. Holt, the School Medical Officer to the Keighley Excepted District:—

I have the honour to submit this, my twenty-sixth Annual Report on the work of the School Health Services of the Borough for the year 1955.

A scheme for the vaccination of older school children against tuberculosis was introduced during the year. Of the number of children offered tuberculin tests and subsequent vaccination if necessary 43.1% accepted. It will take some time to establish confidence in a scheme of this kind and I am well satisfied with the start that has been made.

During the year an investigation into the spread of ringworm was undertaken. This condition had become troublesome and a Wood's diagnostic lamp was brought into use; it proved indispensable and assisted us in bringing the condition under control and finally exterminating it.

The number of cases of whooping cough amongst school children reached a record low and I like to believe that this is the result of the practice of whooping cough immunisation which has been in operation over the last ten years.

I should like to pay tribute to all my colleagues in other branches of the public service for the kind assistance and co-operation and also to my staff for their loyalty and support.

Finally may I express my appreciation to the Headquarter's staff for their readiness to assist in the elucidation of the many minor difficulties which arise from time to time.

I am,

Your obedient Servant,

H. M. HOLT

School Medical Officer.

Co-ordination

The scheme for co-ordination between the Maternity and Child Welfare and School Health Services continues on much the same lines as hitherto, that is to say school clinic facilities are at the disposal of mothers, and children under five years of age by arrangement with the School Medical Officers and the School Dental Surgeons. Specialist services are available where required, cases being referred to the appropriate consultant at the Keighley Victoria Hospital. The West Riding County Council provide for the training and treatment of handicapped pupils and the Regional Hospital Board for the treatment of cases of tuberculosis by arranging admission to Sanatoria or attendance at the local Chest Clinic.

School Hygiene

The School Medical Officers are required to make a superficial inspection of school buildings. In the course of these visits for school medical inspections any improvements thought necessary or deficiencies noted are the subject of a recommendation to the Local Education Authority.

School Medical Inspection

This service provides for the routine medical inspection of all scholars on four separate occasions during their school life with special examinations and re-examinations as necessary, the arrangement being that—

- (a) every pupil who is admitted for the first time to a maintained school shall be inspected as soon as possible after the date of admission;
- (b) every pupil attending a maintained primary school shall be inspected during the year in which the age of eight years is attained;
- (c) every pupil attending a maintained secondary school shall be inspected as soon as possible after admission to such a school;
- (d) every pupil attending a maintained secondary school shall be inspected during the last year of attendance at such a school.

In addition children attending Nursery Schools are examined at least once each year until reaching compulsory school age.

Having regard to the Authority's Youth Employment Service particular attention has been given to the medical examination at paragraph (d) above. The Area Youth Employment Officer is visiting schools and interviewing parents during or near the child's last term at school. In order that he may know whether there is any physical or mental defect which might in the opinion of the School Medical Officer restrict a choice of employment, pupils receive their final periodic medical inspection at the commencement of or immediately prior to entering upon their last term at school. The greatest care is taken to ensure that all information passed to the Area Youth Employment Officer is treated as confidential.

The average number of pupils on the registers at the end of the year was as follows:—

Nursery	40
Primary	5,472
Secondary Modern	1,737
Secondary Grammar	1,244
Secondary Technical	270

The following table gives details of the number of medical inspections corresponding to the various age groups as set out above, viz. (a)=Entrants, (b)=7 to 8 year group, (c)=First year secondary, (d)=Last year secondary.

TABLE I

A. PERIODIC MEDICAL INSPECTIONS

Number of Inspections in the prescribed groups:—

Entrants	769
7 to 8 year group	818
First year secondary	1,032
Last year secondary	614
Other periodic	—
Total	3,233

B. OTHER INSPECTIONS

Number of Special Inspections	2,723
Number of Re-inspections	1,784
Total	4,507

(a) PUPILS FOUND TO REQUIRE TREATMENT AND DEFECTS FOUND

The following table shows the number of individual pupils found at periodic medical inspections to require treatment (excluding Dental Diseases and Infestation with Vermin).

TABLE II

Group	For defective vision (excluding squint)	For any of the other conditions recorded in Table III	Total Individual Pupils
Entrants	2	112	114
7 to 8 year group	31	103	130
First year secondary	59	82	137
Last year secondary	47	48	92
Other Periodic Inspections	—	—	—
Total	139	345	473

(b) DEFECTS FOUND AT MEDICAL INSPECTION IN THE YEAR

All defects noted at medical inspections as requiring treatment are included in the following table whether or not treatment was begun prior to the date of inspection.

TABLE III

Defect or Disease	Periodic Inspections		Special Inspections	
	No. of Defects		No. of Defects	
	Requiring Treatment	Requiring to be kept under observation but not requiring treatment	Requiring Treatment	Requiring to be kept under observation but not requiring treatment
Skin	53	48	184	17
Eyes— <i>a.</i> Vision	139	165	55	55
<i>b.</i> Squint	33	38	19	24
<i>c.</i> Other	13	4	32	10
Ears— <i>a.</i> Hearing	3	13	10	9
<i>b.</i> Otitis Media	8	15	26	9
<i>c.</i> Other	2	8	5	—
Nose or Throat	62	196	32	50
Speech	18	22	76	14
Cervical Glands	7	62	11	15
Heart and Circulation	3	46	5	24
Lungs	24	57	58	33
Developmental— <i>a.</i> Hernia	1	1	2	3
<i>b.</i> Other	4	52	6	20
Orthopaedic— <i>a.</i> Posture	38	12	27	1
<i>b.</i> Flat Foot	44	23	41	10
<i>c.</i> Other	31	41	70	21
Nervous System— <i>a.</i> Epilepsy	5	1	9	3
<i>b.</i> Other	1	14	6	2
Psychological— <i>a.</i> Development	2	11	46	49
<i>b.</i> Stability	1	41	5	14
Other	53	37	771	25

Findings of Medical Inspection

(a) CLASSIFICATION OF GENERAL CONDITION OF PUPILS.

Detailed figures regarding the general condition of pupils as found during the year at periodic medical inspections are shown in the following table:—

TABLE IV

Age Groups (1)	No. of pupils inspected (2)	A (Good)		B (Fair)		C (Poor)	
		No. (3)	% of Col. 2 (4)	No. (5)	% of Col. 2 (6)	No. (7)	% of Col. 2 (8)
Entrants	769	476	61.90	288	37.45	5	0.65
7 to 8 year group	818	573	70.05	242	29.58	3	0.37
First year secondary	1,032	733	71.02	298	28.88	1	0.10
Last year secondary	614	453	73.78	160	26.06	1	0.16
Other Periodic Inspections	—	—	—	—	—	—	—
Total	3,233	2,235	69.13	988	30.56	10	0.31

All cases of poor nutrition are investigated and severe cases are referred for admission to the Open Air School. The provision of free milk and mid-day meals at school has done much to improve the general condition of school children. In addition arrangements have been made for the issue of branded foods free of charge to appropriate cases, the distribution of such foods is made on the authorisation of the School Medical Officer who examines each case prior to an issue being approved. The following foods were distributed under the provisions of this scheme during the year:—

Adexolin	112	Minadex	127
Fersolate	667	Vitamin B	56
Halibut Liver Oil Capsules	858	Vitamin C	575
Maltoline	46		

Infestation with Vermin

The scheme for ensuring cleanliness at schools within the Borough provides, as far as possible, for the inspection of children and their clothing once during each school term throughout the year. Details of the work carried out are given in the following table:—

TABLE V

Total number of examinations in the schools by the school nurses or other authorised persons	21,802
Total number of individual pupils found to be infested	806
Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2) Education Act, 1944)	—
Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3) Education Act, 1944)	—

Treatment Tables

Treatment provided by the Authority includes all defects treated or under treatment during the year by the Authority's own staff irrespective of how the case was brought to the Authority's notice, i.e. whether by periodic inspection, special inspection or otherwise. Treatment provided otherwise than by the Authority includes all treatment known by the Authority to have been so provided including treatment undertaken by the Regional Hospital Board.

GROUP 1. DISEASES OF THE SKIN (EXCLUDING UNCLEANLINESS)

					Number of cases treated or under treatment during the year.	
					<i>By the Authority.</i>	<i>Otherwise.</i>
Ringworm—(1) Scalp .....	.....	.....	.....	.....	8	8
(2) Body .....	.....	.....	.....	.....	13	—
Scabies .....	.....	.....	.....	.....	8	—
Impetigo .....	.....	.....	.....	.....	58	—
Other skin diseases .....	.....	.....	.....	.....	85	—
Total					172	8

In the winter of 1954 and early part of 1955 several cases of ringworm of scalp occurred amongst Keighley school children. In order to investigate the spread of infection a Wood's diagnostic lamp was purchased and examinations were carried out in the affected schools and at the School Clinic. In all, 523 contacts of infected cases were so examined with the consent of their parents and as a result 8 infectious cases were discovered. It is a significant fact that some of these children had already had some treatment but were attending school in a highly infectious condition, they were duly excluded from school and referred to the skin specialist for treatment. The diagnostic lamp remains as a permanent piece of equipment at the school clinic and general practitioners and school medical officers refer suspicious cases for examination.

As in previous years a large part of the work carried out at the minor ailments clinic consisted of the treatment of cuts, abrasions, septic fingers, and skin diseases. The number of cases of scabies among school children was abnormal compared with the figures for the previous four years.

1951	—	Nil
1952	—	1 school child treated
1953	—	Nil
1954	—	Nil
1955	—	8 school children treated.

GROUP 2. EYE DISEASES—DEFECTIVE VISION AND SQUINT

					Number of cases dealt with	
					<i>By the Authority.</i>	<i>Otherwise.</i>
External and other, excluding errors of refraction and squint .....	.....	.....	.....	.....	86	—
Errors of refraction (including squint) .....	.....	.....	.....	.....	—	220
Total					86	220
Number of pupils for whom spectacles were prescribed .....	.....	.....	.....	.....	—	161

During the year 177 cases of defective vision and 43 cases of squint were examined by the Visiting Ophthalmic Surgeon, a further 86 cases suffering from other conditions of the eye such as Blepharitis and Conjunctivitis were treated at the Minor Ailments Clinic.

After testing there were 37 cases in which spectacles were not prescribed, 3 cases where existing spectacles were found to be satisfactory and 19 cases referred to the Bradford Eye and Ear Hospital.

The number of repairs to and replacement of spectacles amounted to 196.

GROUP 3. DISEASES AND DEFECTS OF EAR, NOSE AND THROAT

Received operative treatment:—	Number of cases dealt with:—	
	<i>By the Authority.</i>	<i>Otherwise.</i>
(a) For diseases of the ear	—	—
(b) For adenoids and chronic tonsillitis	—	378
(c) For other nose and throat conditions.....	38	24
Total	38	402

GROUP 4. ORTHOPAEDIC AND POSTURAL DEFECTS

	Number of cases treated:—	
	<i>By the Authority.</i>	<i>Otherwise.</i>
No. treated as in-patients in hospitals	—	—
No. treated otherwise, e.g., in clinics or out-patient departments	382	—
<i>A. Treatment Centres.</i>		
1. No. of sessions held during year	509	
	<i>Pre-School Children</i>	<i>School Children</i>
2. Total number of patients treated (inc. cases continuing treatment from previous year)	24	382
3. Total number of attendances	210	3,498
<i>B. Domiciliary Treatment.</i>		
1. Total number treated	—	
2. Total number of visits to patients' homes	—	
<i>C. Appliances.</i>		
Number of appliances recommended	49	

The following table shows details of the work undertaken by the Authority's Physio-therapist during the year.

TABLE VI

						<i>Number of cases treated</i>	<i>Attendances</i>
<i>School Children</i>							
Asthma						23	234
Bronchitis						11	262
Breathing						58	562
Poor chest development						15	158
Postural drainage						6	91
Flat feet						105	712
Talipes						2	12
Knock knees						25	89
Hallux rigidus						4	52
Claw foot						6	102
Posture						68	438
Kyphosis						5	30
Scoliosis						20	231
Central nervous system						1	26
Anterior Poliomyelitis						6	58
Torticollis						2	22
Rheumatism						8	97
Hemiplegia						5	59
Debility						2	13
Cerebral palsy						3	134
Psoriasis						1	25
Friedrich's ataxia						1	35
Graduated exercises						1	22
Athetoid						1	9
Erbs palsy						1	17
Slight club foot						1	3
Metatarsalgia						1	5
Total						382	3,498
<i>Pre-school Children</i>							
Flat feet						13	136
Knock knees						9	24
Torticollis						2	50
Total						24	210

Attendances at the Orthopaedic Swimming Class — 293.

GROUP 5. CHILD GUIDANCE TREATMENT

No. of pupils treated at Child Guidance Clinics	Number of cases treated	
	<i>In the Authority's</i>	<i>Elsewhere</i>
	<i>Child Guidance Clinic</i>	
No. of pupils treated at Child Guidance Clinics	3	—

Dr. Mary M. MacTaggart resigned her appointment as Psychologist on 31st October, 1955. Dr. Stephanie M. Leese, who was appointed to the post of Child Psychiatrist, holds her nearest clinic at Shipley where children from this area attend. Details of the work carried out during the year is provided in the following table.

TABLE VII

	<i>Boys</i>	<i>Girls</i>	<i>Total</i>
No. of cases continuing attendance from previous year	3	—	3
Total number of cases seen during year	3	—	3
Total number of attendances made during the year for:—			
(a) Individual interview	9	—	9
(b) Group therapy	6	—	6
Types of problem for which cases were referred to the Clinic:—			
(a) Behaviour	1	—	1
(b) Delinquency	—	—	—
(c) Nervous problems	2	—	2
(d) Enuresis	—	—	—
(e) Other	1	—	1

GROUP 6. SPEECH THERAPY

Number of pupils treated by Speech Therapist	Number of cases treated	
	<i>By the Authority</i>	<i>Otherwise</i>
Number of pupils treated by Speech Therapist	88	—

Details of the work carried out by the Authority's Speech Therapist during the year is given in the following table.

TABLE VIII

1. No. of half-day sessions held during year	257
2. No. of new cases treated during year	29
No. of cases attending for treatment from previous year	59
Total number of cases treated	88
3. No. of cases awaiting treatment at end of year	22
4. No. of visits made to schools	—
5. No. of home visits	2

Analysis of cases treated

Analysis of cases discharged

	Number			Number	
	<i>Boys</i>	<i>Girls</i>		<i>Boys</i>	<i>Girls</i>
Stammerers	13	6	Discharges during year	23	11
Defects of Articulation:—			Speech normal	11	6
(a) Dyslalia	20	7	Speech improved	7	2
(b) Sigmatism	7	4	Unsuitable for treatment	—	—
(c) Rhinolia, due to—			Non-co-operation	1	—
(i) Cleft Palate	4	—	Left school	4	2
(ii) Nasal Obstruction	—	1	Left district	—	1
Aphasia	—	—			
Defective speech due to—					
(i) Educational Sub-normality	14	11			
(ii) Deafness	—	—			
Retarded speech development	—	—			
Dysphonia	—	—			
Other defects—					
Dysarthria	1	—			

GROUP 7. OTHER TREATMENT GIVEN

	Number of cases treated.	
	<i>By the Authority</i>	<i>Otherwise</i>
Miscellaneous Minor Ailments	634	—
Ultra Violet Light Treatment	29	—
Total	663	—

In addition to the 634 children who received treatment at the Clinic for miscellaneous minor ailments a further 50 cases were kept under observation, all cases being initially examined by the School Medical Officers.

Of the 29 school children who received ultra violet light treatment at the School Clinic 10 were still under treatment at the end of the year. Through the interavailability of clinics 65 pre-school children received ultra violet light treatment, of these 5 were cured, 54 improved and 6 were still under treatment at the end of the year.

Dental Inspection and Treatment

The arrangement as regards the dental inspection of pupils is that:—

(a) Every pupil who is admitted for the first time to a maintained school shall be inspected by a dental officer as soon as possible after the date of admission, and

(b) Every pupil attending a maintained school or County College shall be inspected by a dental officer on such later occasions as may be practicable and necessary.

Details of the inspections and treatment carried out during the year in connection with this service are given in the following table.

TABLE IX

1. No. of pupils inspected	.....	.....	.....	.....	.....	.....	4,647
2. No. found to require treatment	.....	.....	.....	.....	.....	.....	2,937
3. No. offered treatment	.....	.....	.....	.....	.....	.....	2,937
4. No. treated	.....	.....	.....	.....	.....	.....	2,597
5. Attendances made by pupils for treatment	.....	.....	.....	.....	.....	.....	5,851
6. Extractions:—							
Temporary	.....	.....	.....	.....	.....	.....	4,127
Permanent	.....	.....	.....	.....	.....	.....	1,326
						Total	5,453
7. Administration of General Anaesthetics							931
8. Fillings:—							
Temporary	.....	.....	.....	.....	.....	.....	169
Permanent	.....	.....	.....	.....	.....	.....	3,833
						Total	4,002
9. No. of Other Treatments:—							
Temporary	.....	.....	.....	.....	.....	.....	68
Permanent	.....	.....	.....	.....	.....	.....	1,649
						Total	1,717

Handicapped Pupils

Details of the number of handicapped pupils are given in the following table.

TABLE X

Category	At a Special School	At an Ordinary School	Receiving Home Tuition	At no School	Not receiving suitable education
Blind	1	—	—	1	1
Partially Sighted	4	1	—	—	1
Deaf	6	2	—	—	—
Partially Deaf	2	—	—	—	—
Educationally Sub-normal	7	15	—	—	15
Epileptic	1	2	—	1	1
Maladjusted	3	5	—	—	5
Physically Handicapped	4	11	—	1	1
Speech Defect	—	—	—	—	—
Delicate	94	11	3	2	13
Total	122	47	3	5	37

The Open Air School for Delicate Children

The Open Air School at Braithwaite has accommodation for 50 boys and 50 girls.

The children who attend this school are selected for admission from the secondary modern and primary schools by the School Medical Officers at the routine inspections and at the school clinic. Many children are referred too, by their family doctor, by their teachers, and by their parents, who find that the children are not progressing well at ordinary schools.

After admission, each child is examined by a School Medical Officer at least once each year and the parents are invited to be present at these examinations to discuss their child's health and progress.

The relevant figures for 1955 are given below:—

No. of children on register at 1st January, 1955	90
No. of admissions	38
No. of re-admissions	4
No. of children discharged—	
(a) As fit to attend ordinary school	27
(b) Transferred to Secondary Technical School	1
(c) Transferred to Special Schools	2
(d) Transferred to Hospital Schools	5
(e) On reaching school leaving age	7
No. of children on register at 31st December, 1955	90

Mentally Defective Children

Two children were notified as being ineducable during the year ended 31st December, 1955, under the provisions of Section 57(3) of the Education Act, 1944.

Follow-up of Medical Inspections

The following is a summary of the domiciliary visits made by the Health Visitor/School Nurses throughout the year:—

Infectious diseases	591
Handicapped pupils	24
Neglected and verminous	73
Routine Medical Inspections—	
Follow-up	60
Other visits	64
Total	812

Medical Examination of Entrants to Training Colleges

Twenty-five students were medically examined during the year in connection with their applications for entry to Training Colleges.

Infectious Diseases

Details are given below of the final numbers according to sex and age, after corrections subsequently made either by the notifying medical practitioner or by the medical superintendent of the infectious diseases hospital, of all cases of infectious and other notifiable diseases which occurred in children resident within the Borough up to and including the age of 14 years throughout the year.

TABLE XI

Final Numbers after correction	Scarlet Fever		Whooping Cough		Acute Poliomyelitis				Measles	
	M	F.	M.	F.	Paralytic		Non-paralytic		M.	F.
					M.	F.	M.	F.		
Under 1 year	—	—	—	2	—	—	—	—	13	13
1—2 years	2	1	2	1	—	—	—	—	117	124
3—4 years	3	5	1	2	—	—	—	—	206	176
5—9 years	6	12	2	3	—	—	—	1	256	281
10—14 years	2	1	—	—	—	—	—	—	4	5
Total	13	19	5	8	—	—	—	1	596	599

Final Numbers after correction	Acute Pneumonia		Dysentery		Acute Encephalitis		Tuberculosis					
	M.	F.	M.	F.	M.	F.	Respiratory		Meninges & C.N.S.		Other	
							M.	F.	M.	F.	M.	F.
Under 5 years	6	8	—	2	1	—	—	—	—	2	—	—
5—14 years	1	4	4	5	—	—	1	—	1	—	3	—
Total	7	12	4	7	1	—	1	—	1	2	3	—

Immunisation against Diphtheria and Whooping Cough

(a) *Diphtheria*—Facilities are offered free of charge to the parent or guardian of every child for immunisation against diphtheria either by the Authority's staff or by a registered medical practitioner. Details of the number of children immunised against diphtheria are given in the following table:—

TABLE XII

No. of children who received a full course of primary immunisation			No. of children who received re-inforcing injections
0—4	5—14	Total	
322	43	365	292

(b) *Whooping Cough*—The Authority's scheme for immunisation against whooping cough takes the same lines as that for immunisation against diphtheria. Details of the number of children immunised against whooping cough are given in the following table:—

TABLE XIII

No. of children who received a full course of immunisation				
Under 6 months	6 mths. to 1 year	1 and under 2	2 and under 3	3 and under 4
19	200	58	13	9

Protection of School Children against Tuberculosis

(a) *Tuberculin Testing of School Entrants.* The following shows details of the work undertaken during the year under the provisions of the scheme for the routine tuberculin testing of school entrants:—

Number Invited	Number Refused	No. found to have been tested elsewhere	Number Accepted	Negative	Positive	Absentees
214	45	3	166	126	5	35

Tuberculin testing was introduced in order that in the case of a positive result it would lead to a search for a source of infection and at the same time secure the placing of the child under medical supervision in order to avoid the risks which follow primary infection.

(b) *B.C.G. Vaccination of Older School Children.* A scheme for the vaccination against tuberculosis of thirteen-year-old school children was introduced during the year. The details of the work undertaken in this connection are set out below:—

No. of medical officers approved to undertake B.C.G. Vaccination	1
Date of first pre-vaccination test	19th May, 1955.
Acceptances—	
No. of 13-year-old children on register at beginning of year	545
No. of children offered tuberculin testing and vaccination if necessary	272
No. of children found to have been vaccinated previously	3
No. of acceptances	116
Percentage of acceptances	43.1
Pre-vaccination Tuberculin Test—	
No. of children tested	115
Result of test — Positive	34
Negative	78
Not ascertained	3
Total	115
Percentage positive	30.3
Vaccination—	
No. vaccinated	78

Co-operation of Teachers, Welfare Officers, Home Nurses and Voluntary Bodies

(a) *Teachers.*

Teachers assist in the work of the School Medical Service by selecting children suffering from defects and by referring them to the school clinic greatly assist the School Medical Officer in treating them.

(b) *Welfare Officers.*

As usual the Welfare Officers meet with mentally and physically defective children during the course of their home visits, and by referring them to the school clinic greatly assist the School Medical Officer in treating them.

(c) *Home Nursing Service.*

The Home Nurses are always ready to assist where children require nursing treatment at home.

(d) *Voluntary Bodies.*

(1) THE CRAVEN BRANCH OF THE NATIONAL SOCIETY FOR THE PREVENTION OF CRUELTY TO CHILDREN.

As in previous years a high degree of co-operation has been maintained between the National Society for the Prevention of Cruelty to Children and this department. By the pooling of knowledge and resources much can be done and is done to assist appropriate cases.

(2) THE KEIGHLEY INFANT AID SOCIETY.

The Keighley Infant Aid Society provides assistance in such cases as are appropriate to its sphere of activity.

Miscellaneous

Swimming Instruction.

THE REPORT OF THE BATHS SUPERINTENDENT. ELEMENTARY SCHOOLS' SWIMMING, 1955.

Class Attendances.				Attendances by individuals on 2d. tickets			
Boys	.....	.....	4,087	Boys	.....	.....	2,296
Girls	.....	.....	3,911	Girls	.....	.....	1,060

RESULTS OF INSTRUCTIONS

Preliminary Certificate 125.

Elementary Certificate 192.

The children passing for the Borough Elementary Swimming Certificate also receive a free pass to the Second Class Swimming Bath for twelve months.

Particulars of Clinics held, showing day, time and frequency of sessions and staff in attendance, as at 31st December, 1955.
See note at end of table for explanation of abbreviations.

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
DIV. 1. (SKIPTON) Addingham Mobile Clinic ...	—	Thurs. p.m. (alternate) DMO/HV Wed. p.m./HV Thurs. p.m. ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Barnoldswick The Butts ...	Fri. a.m./p.m. (1st & 3rd) ACMO/HV/M Wed. p.m. M Relax.	Wed. p.m. (alternate) ACMO/HV Thurs. a.m. ACMO/HV Wed. a.m. (alternate) ACMO/HV	Wed. p.m. Fri. a.m. H.V.	—	Thurs. a.m. (alternate) ACMO/HV	Mon. p.m. Wed. a./p.m. S.T.	—	—	—	—	as required HMO/HV	—	—	—	—
Barnoldswick Kelbrook Rd. ...	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Bradley Mobile Clinic ...	—	Wed. a.m. (alternate) ACMO/HV Thurs. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Carleton Mobile Clinic ...	—	Thurs. a.m. ACMO/HV Wed. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Cononley Mobile Clinic ...	—	Wed. a.m. (alternate) ACMO/HV Wed. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Cowling Mobile Clinic ...	—	Wed. p.m. (alternate) ACMO/HV Tues. p.m. (alternate) ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Crosshills Ebenezer Sunday School	Tues. a.m. (alternate) ACMO/HV/M	Thurs. p.m. (alternate) HV Wed. p.m. (alternate) GP/HV Wed. a.m. HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Earby Old Grammar School ...	Fri. p.m. (2nd and 4th) ACMO/HV(2)/M Tues. p.m. M Relax.	Thurs. a.m. (alternate) ACMO/HV Thurs. p.m. (alternate) DMO/HV Wed. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Embsay Mobile Clinic ...	—	Thurs. a.m. (alternate) ACMO/HV Thurs. p.m. (alternate) DMO/HV Wed. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Gargrave The Institute ...	—	Thurs. p.m. (alternate) DMO/HV Wed. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Grassington Church House ...	—	Tues. p.m. (alternate) ACMO/HV(2) Thurs. p.m. (alternate) HV Wed. p.m. ACMO/HV(2)	—	—	Tues. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Silsden Kirkgate Methodist Sunday School ...	—	Thurs. p.m. (alternate) HV Wed. p.m. ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Skipton Millfields Hall ...	—	Thurs. p.m. ACMO/HV(2)	—	—	Fri. a.m. (2nd & 4th) ACMO/HV	Fri. a./p.m. S.T.	—	—	—	—	as required HMO/HV	—	—	—	—
DIV. 2. (SETTLE) Austwick Mobile Clinic ...	—	Tues. p.m. (every 4 weeks) HV Thurs. p.m.	—	—	—	—	—	—	—	—	—	—	—	—	—
Bentham	—	Thurs. p.m.	—	—	—	—	—	—	—	—	—	—	—	—	—

[illegible]

CLINICS—(continued)

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Keighley 147, Skipton Road ...	—	—	Wed. a.m. Sat. a.m. ON	Daily HV	Mon. a.m. Thurs. a.m. Sat. a.m. ACMO/HV	Mon. a.m. Tues. p.m. Wed. a.m. Fri. a./p.m. ST	Fri. p.m. (last in mth.) ACMO/HV	—	Mon. a./p.m. Tues. a.m. Wed. a./p.m. Th. a./p.m. Fri. p.m. ON	—	Tues. a.m. (alternate) HMO/HV	—	—	Daily	—
Oakworth Methodist Sunday School	Thurs. p.m. (alternate) before I.W. ACMO/HV/M	Thurs. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Oxenhope Methodist Sunday School	Thurs. p.m. (alternate) before I.W. ACMO/HV/M	Thurs. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Morton Memorial Institute, East Morton ...	—	Fri. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 4. (SHIPLEY)															
Baildon Methodist School ...	Wed. a.m. (alternate) GP/HV/M	Mon. p.m. GP/HV(2)	—	Mon. a.m. H.V.	—	—	—	—	—	—	—	—	—	—	—
Bingley County Secondary School	—	—	—	At S.C.	Fri. a.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—
Bingley Old Technical Institute, Morningside Road. ...	Tues. p.m. ACMO/M(2) Wed. p.m. M/HV Relax.	Thurs. p.m. ACMO/HV(2)	Mon. p.m. Fri. p.m. HV	Daily a.m. HV	Fri. p.m. ACMO/HV	Mon. p.m. ST	—	—	Mon. p.m. ON	—	—	—	—	Daily	—
Cottingham Town Hall ...	—	Wed. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Cullingworth Church School ...	—	Tues. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Denholme Methodist School ...	With Infant Welfare	Wed. p.m. (alternate) GP/HV/M	—	—	—	—	—	—	—	—	—	—	—	—	—
Harden (Bingley) Memorial Hall ...	—	Wed. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Shipley Somerset House ...	Tues. p.m. M(2) Wed. p.m. ACMO/M(2) Tues. p.m. M/ON Relax.	Tues. p.m. ACMO/HV(3) Thurs. p.m. ACMO/HV(2)	Wed. a.m. Sat. a.m. HV	Daily a.m. HV	Thurs. p.m. ACMO/HV	Tues. a.m. Thurs. a./p.m. ST	Thurs. a.m. ACMO/HV	Fri. a./p.m. PSW	Tues. p.m. Wed. a.m. Thurs. p.m. and Fri. a.m. (alternate) ON	—	Th. a./p.m. HMO/HV	Mon. p.m. (monthly) HMO/ON	—	Daily	E.N.T. Tues. a.m. (monthly) HMO/HV Dermato- logical Mon. a.m. (monthly) HMO/HV Audiometry Fri. p.m. HV
Shipley 105, Wrose Road ...	—	Tues. a.m. HV Fri. p.m. ACMO/HV(2)	—	Fri. a.m. HV	—	—	—	—	—	—	—	—	—	—	—

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Otley Whiteley Croft ... Pool-in-Wharfedale Church Room ...	— —	— Mon. p.m. (alternate) DMO/HV	— —	— —	— —	Tues. p.m. ST	— —	— —	— —	— —	— —	— —	— —	— —	— —
DIV. 7. (RIPON) Birstwith Mobile Clinic ...	—	Mon. p.m. (4 weekly) DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	Cardiac see Div. 8
Bishop Monkton Mobile Clinic ...	—	Fri. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Bishop Thornton Mobile Clinic ...	—	Mon. a.m. (4 weekly) DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Copt Hewick Mobile Clinic ...	—	Tues. p.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Dacre Mobile Clinic ...	—	Mon. p.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Darley Mobile Clinic ...	—	Mon. p.m. (alternate) DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Galphay Mobile Clinic ...	—	Tues. a.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Grewelthorpe Mobile Clinic ...	—	Tues. a.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Kirkby Malzeard Mobile Clinic ...	—	Tues. a.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Lofthouse Mobile Clinic ...	—	Mon. a.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Markington Mobile Clinic ...	—	Mon. a.m. (4 weekly) DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Mickley Mobile Clinic ...	—	Tues. a.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
North Stainley Mobile Clinic ...	—	Tues. p.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Nunwick Mobile Clinic ...	—	Tues. p.m. (4 weekly) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Pateley Bridge Methodist Buildings ...	—	Wed. p.m. (1st & 3rd) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Pateley Bridge Welfare Centre, Council Offices ...	Thurs. p.m. GP/HV(2)	Mon. p.m. ACMO/HV(2)	Mon. a.m. ACMO/HV Thurs. a.m. DMO/HV	Daily a.m. HV(2)	Fri. a.m. ACMO/HV	—	—	—	—	—	As required HMO/HV	—	—	—	—
Ripon Alma House ...	—	—	—	—	Mon. a.m. ACMO/ HV(2)	Wed. a.m. Fri. a./p.m. ST	—	—	—	—	Tues. p.m. HMO/HV	Fri. p.m. (3rd in mth.) HMO/HV	Fri. p.m. (2nd in mth.) HMO/ HV(2)	Daily	—

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Knaresborough Fysche Hall	—	Tues. p.m. ACMO/HV Thurs. p.m. (2nd & 4th) ACMO/HV Wed. p.m. (2nd & 4th) ACMO/HV Thurs. p.m. (1st & 3rd) GP/HV	—	—	Mon. a.m. Thurs. a.m. ACMO/HV	—	—	—	—	Mon. p.m. Wed. p.m. MH	Fri. a./p.m. (3rd in mth.) HMO/HV	—	—	—	—
Poppleton Church Hall	—		—	—	—	—	—	—	—	—	—	—	—	—	—
Whixley Village Hall	—		—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 9. (WETHERBY)															
Appleton Roebuck Mobile Clinic	With Infant Welfare	Thurs. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Bardsey Trustees Hall	—	Mon. p.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Barwick-in-Elmet Methodist Schoolroom ...	With Infant Welfare	Tues. p.m. (alternate) GP/HV(2) Tues. a.m. (alternate) HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Boston Spa West End Nursery School	With Infant Welfare	Wed. p.m. (alternate) ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Bramham Mobile Clinic	With Infant Welfare	Fri. a.m. (alternate) GP HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Copmanthorpe Mobile Clinic	With Infant Welfare	Thurs. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Church Fenton Methodist Sunday School	With Infant Welfare	Wed. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Church Fenton R.A.F. Station	With Infant Welfare	Thurs. p.m. (alternate) MO(RAF)/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
East Keswick Mobile Clinic	With Infant Welfare	Fri. a.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Huby Mobile Clinic	With Infant Welfare	Fri. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Ledston Mobile Clinic	With Infant Welfare	Wed. a.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Micklefield Methodist Chapel	With Infant Welfare	Tues. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Scholes Mobile Clinic	With Infant Welfare	Wed. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—

[illegible]

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Altofts Upper Altofts Methodist Church ...	—	Wed. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Castleford Castledene ...	Fri. p.m. M <i>Relax.</i>	—	Tues. a.m. Fri. a.m. HV(2)	—	—	Tues. a./p.m. Fri. a./p.m. ST	—	—	—	—	Wed. a./p.m. HMO/HV	Tues. a.m. (4th in mth.) HMO/HV	Wed. p.m. (3rd in mth.) HMO/HV	—	—
Castleford Barnes Road ...	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Castleford Methodist Church, Hightown ...	Thurs. p.m. GP/HV/M(2)	Mon. p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
Castleford Hightown Hospital ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	E.N.T. Wed. p.m. (alternate) HMO/HV
Castleford Old Council Offices, Sagar Street ...	Wed. p.m. GP/HV(2)/ M(2)	Mon. p.m. Thurs. p.m. GP/HV(2)	—	Mon. a.m. Wed. a.m. Fri. a.m. HV	Wed. a.m. ACMO/ HV(2)	—	—	—	—	—	—	—	—	—	—
Glasshoughton St. Paul's Church ...	Wed. p.m. (2nd & 4th) GP/HV/M	Tues. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Normanton Park Pavilion ...	Wed. p.m. ACMO/HV/ M(2) Mon. p.m. M(2) <i>Relax.</i> Mon. p.m. Thurs. p.m. M(2) <i>U.V. Light</i>	Tues. p.m. Thurs. p.m. ACMO/HV(2)	Tues. p.m. Fri. p.m. HV(2)	Daily a.m. HV	Tues. a.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—
DIV. 12. (PONTEFRACT)															
Beal Methodist Chapel ...	—	Thurs. p.m. (alternate) DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Carleton Community Centre ...	—	Wed. p.m. DMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Featherstone Albert Street ...	Tues. p.m. ACMO/HV/ M(3) Mon. p.m. M(2) <i>Relax.</i>	Wed. p.m. ACMO/HV(2) Thurs. p.m. (2nd & 4th) GP/HV, <i>Toddlers</i>	—	Daily a.m. HV	Mon. a.m. (1st & 3rd) ACMO/HV	Mon. a./p.m. ST	Thurs. a.m. (1st in mth.) ACMO/HV	—	—	Mon. p.m. Tues. a.m. MH	—	—	—	—	—
Ferrybridge Wesleyan Chapel...	Tues. p.m. (1st & 3rd) GP/HV/M(2)	Wed. p.m. GP/HV(3)	—	Wed. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Knottingley Chapel Street ...	Tues. p.m. (2nd & 4th) GP/HV/M(2) Thurs. p.m. (1st & 3rd) GP/HV/M(2)	Mon. p.m. GP/HV(3)	—	Mon. a.m. Fri. a.m. HV	Mon. a.m. (2nd & 4th) ACMO/ HV(2)	Thurs. a.m. ST	—	—	—	Wed. p.m. Fri. p.m. MH	—	—	—	—	—
Knottingley	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—

Pontefract	Headlands Road	...	Fri. a.m. DMO/HV/ M(2)	Mon. a./p.m. ACMO/HV(2)	Tues. a.m. Fri. a.m. HV	Daily HV	Thurs. a./p.m. ACMO/HV	—	Tues. p.m. (2nd & 4th) DMO/HV	—	Wed. a.m. ON	Mon. a.m. Thurs. p.m. MH	Thurs. a.m. HMO/HV	Tues. p.m. (1st in mth.) HMO/ON	—	Daily	E.N.T. Wed. p.m. (alternate) HMO/HV
Streethouse Methodist Chapel	— Tues. p.m. Wed. p.m. M <i>Relax.</i>	Mon. p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 13. (MORLEY)																	
Crigglestone Village Institute	With Infant Welfare	Wed. p.m. ACMO/HV/M	—	Wed. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Crofton Mission Hall	With Infant Welfare	Mon. p.m. ACMO/HV/M	—	—	—	—	—	—	—	—	—	—	—	—	—
Crofton Parochial Hall	—	—	—	Mon. a.m. Thurs. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Drighlington Methodist School	Thurs. p.m. (2nd & 4th)	Fri. p.m. GP/HV	—	Tues. p.m. Fri. p.m. HV	—	—	—	—	—	—	—	—	—	—	—
East Ardsley Methodist School, The Falls	With Infant Welfare	Tues. p.m. GP/HV	—	Tues. p.m. Fri. p.m. HV	—	—	—	—	—	—	—	—	—	—	—
Gildersome Council Offices	Thurs. p.m. (1st & 3rd) M <i>Relax.</i>	Wed. p.m. ACMO/HV	—	Mon. p.m. Wed. p.m. HV	—	—	—	—	—	—	—	—	—	—	—
Horbury Congregational School, Tithe Barn Street	Thurs. p.m. ACMO/M	Mon. p.m. GP/HV	—	Mon. a.m. Thurs. a.m. HV	Thurs. a.m. (1st in mth.) ACMO/ HV(2)	—	—	—	—	—	—	—	—	—	—
Middletown Church School	With Infant Welfare	Tues. p.m. ACMO/HV/M	—	—	—	—	—	—	—	—	—	—	—	—	—
Morley Corporation Street	Fri. p.m. ACMO/M(2)	Mon. p.m. Wed. p.m. ACMO/HV(2)	Tues. p.m. Thurs. p.m. HV	Daily a./p.m. HV	Tues. a.m. Fri. a.m. ACMO/HV	Fri. a./p.m. (alternate) ST	Fri. a.m. ACMO/HV	—	Wed. a.m. HV	—	2/3 monthly as required HMO/HV	—	Wed. p.m. (2nd & 4th) HMO/HV	Daily	—
Ossett Croft House	Mon. p.m. Fri. p.m. ACMO/ M(3) Wed. p.m. M <i>Relax.</i>	Mon. p.m. GP/HV(2) Thurs. p.m. ACMO HV(2)	—	—	Tues. a.m. Fri. a.m. ACMO/HV	Mon. a./p.m. Wed. a.m. ST	Wed., (1st for under 5's and 2nd for over 5's) GP/HV	—	—	—	Mon.a./p.m. (2nd in mth) HMO/HV	—	—	Daily	...
Sharlston St. Luke's Hall	Fri. p.m. With Infant Welfare	Tues. p.m. ACMO/HV/M	—	Tues. a.m. Fri. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Wakefield Central Dental Clinic, Bond Street	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Wakefield County Health Depart- ment	—	—	—	—	—	—	—	—	—	—	Mon. a./p.m. Fri. a./p.m. As required HMO/HV	—	—	—	—
Wakefield Pinderfields Hospital	—	—	—	—	—	—	—	—	—	—	—	Wed. p.m. (monthly) HMO/ON Includes Div. 16.	—	—	—

CLINICS—(continued)

[illegible]

Methley Red House	...	Wed. a.m. ACMO/HV/ M	Mon. p.m. (alternate) HV Wed. p.m. ACMO/HV Wed. p.m. (alternate) HV Tues. p.m. (alternate) Tues. p.m. (alternate) HV Wed. p.m. ACMO/HV	—	—	—	—	—	—	—
Oulton Harold Hall Institute, Quarry Hill	...	—	—	—	—	—	—	—	—	—
Outwood Rebooth Methodist Chapel, Leeds Road	...	Fri. a.m. (alternate) ACMO/HV/ M	—	—	—	—	—	—	—	—
Rothwell Oulton Lane	...	Thurs. a./p.m. DMO/HV/M Tues. p.m., M Relax.	Mon. p.m. DMO/HV	Tues. a./p.m. Wed. p.m. ST	—	—	—	—	Fri. a.m. (2nd in mth.) HMO/HV	E.N.T. As required HMO/HV
Rothwell Carlton Lane	...	—	—	—	—	—	—	—	Daily	—
Stanley Zion Congregational Chapel, Aberford Road	...	Mon. a.m. (alternate) ACMO/HV/ M	Thurs. p.m. ACMO/HV Mon. p.m. HV	—	—	—	—	—	—	—
Thorpe Womens Institute	...	—	Wed. a.m. (alternate) ACMO HV Wed. a.m. (alternate) HV	—	—	—	—	—	—	—
Wrenthorpe St. Anne's Church Rooms	...	Mon. p.m. ACMO/HV/ M	Mon. p.m. (alternate) ACMO/HV Mon. p.m. (alternate) HV	—	—	—	—	—	—	—
DIV. 17. (SPENBOROUGH)										
Birkenshaw Old Lane	...	Wed. p.m. ACMO/HV/ M	Tues. p.m. ACMO/HV(2)	—	—	—	—	—	—	—
Cleckheaton Elm Bank	...	Thurs. p.m. ACMO/HV/ M(2) Tues. p.m. (alternate) M Relax. Wed. p.m. (alternate) M Relax.	Wed. p.m. ACMO/HV(2) Wed. p.m. (alternate) HV(2) Mothers	Mon. p.m. Tues. p.m. HV	Mon. a.m. ACMO/HV	—	Fri. a./p.m. ON	Mon. p.m. Tues. p.m. HMO/HV	Mon. a.m. (alternate) HMO/HV	Chiropody Thurs. a.m. Ch
Gomersal Public Hall	...	—	Fri. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—
Liversedge Valley Road	...	Mon. p.m. ACMO/HV/ M(2)	Tues. a.m. Sat. a.m. HV	Thur. a/p.m. ST	—	—	—	—	—	Chiropody Mon. a.m. Ch
Mirfield Ings Grove	...	Wed. p.m. ACMO/HV/M Mon. p.m., M Relax.	Fri. p.m. ACMO/HV(2) Sat. a.m. HV	Mon. p.m. ST	—	—	Wed. a.m. ON	As required HMO/HV	—	Chirophdy Fri. a.m. Ch

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Roberttown Sunday School ...	—	Thurs. p.m. (3rd in month) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Scholes Temperance Hall...	—	Thurs. p.m. (2nd in month) ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
DIV. 18. (BRIGHOUSE)															
Brighthouse Bonagate House	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Brighthouse 10, Huddersfield Road ...	Tues. p.m. (alternate) ACMO/HV/M	Wed. p.m. GP/HV(2) Thurs. p.m. DMO/HV	—	—	—	—	Fri. a.m. As required DMO/HV	—	—	—	—	—	—	—	—
Brighthouse Atlas Mill Road ...	Tues. p.m. Fri. p.m. HV Relax.	—	Mon. a.m. Thurs. a.m. HV	Daily HV	Thurs. a.m. ACMO/HV	Mon. a.m. Tues. a./p.m. ST	—	—	Tues. a.m. HV	—	Thurs. a.m. (alternate) Fri. a.m. HMO/HV	Fri. p.m. (monthly) HMO/HV	—	—	E.N.T. Mon. a.m. (as required) HMO/HV
Elland St. Paul's School	Mon. p.m. (alternate) DMO/HV/M	Wed. p.m. DMO/HV(2)	Mon. a.m. Wed. a.m. HV	Mon. a.m. Wed. a.m. HV	Wed. a.m. (alternate) DMO/HV	—	—	—	—	—	—	—	—	—	—
Greetland Clay House ...	Mon. p.m. HV Relax. Wed. p.m. (alternate) ACMO/HV/M	Tues. p.m. GP/HV(2)	Mon. p.m. Thurs. p.m. HV	Tues. a.m. Thurs. a.m. HV	Tues. a.m. (3rd in mth.) DMO/HV	—	—	—	Tues. a.m. HV	—	Thurs. a.m. (alternate) HMO/HV	—	—	—	—
Hipperholme Wesleyan School	Fri. p.m. (alternate) ACMO/HV/M	Mon. p.m. ACMO/HV(2)	Mon. a.m. Fri. a.m. HV	—	Mon. a.m. DMO/HV	—	—	—	—	—	—	—	—	—	—
Queensbury Cricket Pavilion	Fri. p.m. (alternate) M Relax. Fri. p.m. (alternate) ACMO/HV/M	Tues. p.m. ACMO/HV(2)	Tues. a.m. Fri. a.m. HV	Tues. a.m. Fri. a.m. HV	Fri. a.m. (2nd in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Shelf Witchfield Chapel	Fri. p.m. (alternate) M Relax. Mon. p.m. ACMO/HV/M	Mon. p.m. ACMO/HV	Mon. a.m. HV	Mon. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Southowram St. Anne's in the Grove...	Thurs. p.m. ACMO/HV/M	Thurs. p.m. ACMO/HV	Mon. a.m. Thurs. a.m. HV	Thurs. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
DIV. 19. (TODMORDEN)															
Halifax Royal Infirmary ...	—	—	—	—	—	—	—	—	—	—	—	Wed. a.m. (bi-monthly) HMO	—	—	—
Hebden Bridge Pitt Street ...	Fri. p.m. GP/HV/M(2) Tues. p.m. M(2) Relax.	Wed. p.m. Thurs. p.m. GP/HV(2)	Mon. p.m. Thurs. a.m. HV(2) Oct.—Apl.	—	Wed. a.m. ACMO/HV	Tues. a.m. ST	—	—	—	—	As required HMO/HV	—	—	—	—

[illegible]

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Honley Council Offices ...	—	—	—	—	—	Thurs. p.m. ST	—	—	—	—	—	—	—	—	—
Honley Dental Clinic	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Honley Council Offices ...	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Honley High Street Methodist Church ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Honley Southgate Methodist Schools ...	—	Fri. p.m. ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Huddersfield Divisional Education Offices ...	—	—	—	—	—	Wed. p.m. (alternate) Mon. p.m. (alternate) ST	—	—	—	—	—	—	—	—	—
Huddersfield Old Boys' Pavilion, Tandem, Waterloo	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Huddersfield Royal Infirmary ...	—	—	—	—	—	—	—	—	—	—	—	Fri. p.m. (4 weekly) HMO/HV	—	—	E.N.T. Mon. a.m. as required HMO/HV
Kirkburton Drill Hall ...	—	Tues. p.m. ACMO HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Kirkburton C. of E. School ...	—	—	—	—	—	Wed. p.m. (alternate) ST	—	—	—	—	—	—	—	—	—
Lepton Council Offices, Wakefield Road ...	Thurs. p.m. (3rd in month) ACMO/HV/ M Tues. a.m. M Relax.	Thurs. p.m. ACMO/HV Toddlers quarterly by arrangement ACMO/HV Tues. p.m. ACMO/HV Toddlers quarterly by arrangement ACMO/HV Thurs. p.m. GP/HV Toddlers quarterly by arrangement ACMO/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Linthwaite Methodist Church, Stones Lane ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Marsden Conservative Club	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Marsden Mechanics' Institute	—	—	—	—	—	—	—	—	—	—	As required HMO/HV	—	—	—	—
Meltham Baptist School ...	Thurs. p.m. (1st in month) ACMO/HV/ M Tues. a.m. M Relax.	Tues. p.m. GP/HV Toddlers quarterly by arrangement ACMO/HV	—	Tues. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Meltham	—	—	—	—	—	—	—	—	—	—	As required	—	—	—	—

[illegible]

Shafton Methodist Chapel	...	—	Thurs. p.m. (alternate) GP/HV(2)	—	—	—	—	—	—	—	—	—	—
South Elmsall P.I.C.S. Buildings, Barnsley Road ...	...	Thurs. a./p.m. ACMO/HV/ M Wed. p.m. M Relax.	Mon. a./p.m. GP/HV(2)	—	—	—	—	—	—	—	—	—	—
South Hiendley Methodist Chapel	...	—	Wed. p.m. (alternate) GP/HV(2)	—	—	—	—	—	—	—	—	—	—
South Kirkby P.I.C.S. Buildings, The Green ...	...	Tues. p.m. ACMO/HV/ M(2) Thurs. p.m. M(2) Relax.	Mon. p.m. ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—
Upton Church Hall	...	—	Tues. p.m. (alternate) GP/HV(2)	—	Mon. p.m. HV	—	—	—	—	—	—	—	—
DIV. 25. (BARNESLEY) Barnsley Divisional Office, 6, Victoria Road	...	—	—	—	—	—	—	—	—	Mon. a.m. Thurs. a.m. or Fri. a.m. (alt'rnat'g) HMO HV	Fri. a.m. Monthly as required HMO/HV Includes Div. 22	Mon. a.m. (1st in mth.) Thurs. a.m. (3rd in mth.) HMO/HV	—
Barnsley Beckett Hospital ...	...	—	—	—	—	—	—	—	—	—	—	—	E.N.T. Tues. a.m. (2nd in mth.) HMO/HV See also Div. 30.
Cudworth St. George's Hall	...	Fri. a.m. GP/HV/M Thurs. a.m. M(2) Relax. Fri. a.m. GP/HV/M Wed. a.m. M(2) Relax. Wed. p.m. With I.W. GP/HV/M Tues. p.m. M Relax. Tues. a.m. M Relax.	Wed. a./p.m. GP/HV(2)	Tues. p.m. Thurs. p.m. HV(2) Oct.—May	—	Tues. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—
Darfield Methodist Church, Barnsley Road ...	...	—	Wed. p.m. GP/HV	—	—	Wed. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—
Darton Station Road ...	...	—	Wed. p.m. GP/HV	—	Wed. a.m. (1st in mth.) HV	Mon. p.m. (alternate) ACMO/HV	—	—	—	Fri. a./p.m. MH	—	—	—
Dodworth Mechanics' Institute	...	—	Tues. p.m. GP/HV	—	Tues. a.m. (alternate) HV	Tues. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—
Higham Parish Hall, Higham Common Road ...	...	Tues. p.m. DMO/HV/M with Inf. Wel.	Tues. p.m. DMO/HV	—	Tues. a.m. HV	Wed. a.m. (3rd in mth.) ACMO/HV	—	—	—	—	—	—	—

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Royston Wesleyan Sunday School, High Street ...	Tues. p.m. GP/HV/M	Wed. a./p.m. GP (1 session) /HV	—	Mon. a.m. HV	Fri. a.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Staincross Wesleyan Sunday School, Barnsley Road ...	Thurs. p.m. With Infant Welfare DMO HV/M	Thurs. p.m. DMO/HV	—	Thurs. a.m. (except 2nd) HV	Thurs. a.m. (2nd in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Wombwell Public Library, Station Road ...	Thurs. a./p.m. GP/HV(2)/M(2) Mon. a.m. Wed. p.m. M(3) Relax.	Tues. p.m. GP/HV(4)	Mon. p.m. Fri. p.m. HV	Fri. p.m. HV Mon. p.m. (alternate) HV	Mon. p.m. (alternate) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Wombwell Welfare Hall, Jump Wombwell ...	—	Mon. p.m. GP/HV(2)	—	—	—	—	—	—	—	Tue. a./p.m. Wed. a./p.m. MH	—	—	—	Daily	—
Worsbrough Methodist Church, Birdwell ...	Fri. p.m. (alternate) GP/HV/M Fri. p.m. M Relax.	Wed. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Worsbrough Methodist Chapel, Blacker Hill ...	—	Thurs. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Worsbrough Ambulance Hall, Worsbrough Bridge ...	Tues. p.m. (alternate) GP/HV/M Thurs. p.m. M Relax.	Mon. p.m. GP/HV	—	Mon. a.m. (alternate) HV	Mon. a.m. (alternate) ACMO/HV	—	—	—	—	Thurs. a.m. MH	—	—	—	—	—
Worsbrough Bank End Community Centre, Worsbrough Dale ...	Tues. p.m. (alternate) GP/HV/M Wed. p.m. M Relax.	Thurs. p.m. GP/HV	Mon. p.m. Fri. p.m. HV	Thurs. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
DIV. 26. (WATH) Kilnhurst Church Hall ...	—	Wed. p.m. GP/HV(2)	—	—	Thurs. a.m. (2nd in mth.) ACMO/HV	—	—	—	—	—	—	—	—	—	E.N.T. See Div. 30
Parkgate Methodist Church, Broad Street ...	—	Thurs. p.m. ACMO/HV(2)	—	—	Tues. p.m. (monthly) ACMO/HV	—	—	—	—	—	—	—	—	—	—
Rawmarsh Barbers Avenue ...	Thurs. a.m. GP/HV(2)/M Thurs. p.m. M Relax.	Tues. p.m. GP/HV(3)	Mon. a.m. Thurs. p.m. HV	—	Wed. a.m. ACMO/HV	—	—	—	—	Mon. p.m. Wed. p.m. MH	Mon. a./p.m. (3 weekly) Wed. a./p.m. (3 weekly) HMO/HV	Wed. p.m. (monthly) HMO/HV Includes Div. 31	Thurs. a.m. (1st in mth.) HMO/ACMO/HV Dev. (monthly) HMO/HV Includes neighbour's divisions	Daily	—

[illegible]

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Doncaster Nether Hall Road Methodist Church ...	—	—	—	—	—	—	—	—	Mon. a.m. ON	—	—	—	—	—	—
Doncaster Chest Clinic, Merton House, 20, Christ Church Road ...	—	—	—	—	—	—	—	—	—	—	—	Thurs. p.m. (4th in mth.) HMO/ON for Divs. 27, 28, 29 & 30	—	—	—
Doncaster Royal Infirmary ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	E.N.T. Wed. a.m. (3rd in mth.) HMO/HV
Doncaster Wood Street ...	—	—	—	—	—	—	—	—	—	—	Thurs. a./p.m. (alternate) HMO/HV	—	—	—	—
Edlington St. John's Church Hall ...	Thurs a./p.m. (1st, 3rd & 4th) ACMO/HV (2)/M	Mon. p.m. ACMO/HV(2)	—	Mon. a.m. Fri. a.m. HV	—	—	Fri. a.m. (monthly) ACMO/HV	—	—	—	—	—	—	—	—
Kirk Sandall Denton Green's Lane ...	Tues. p.m. (1st & 3rd) ACMO/ HV(2) M	Thurs. p.m. GP/HV/M	—	Tues. a.m. Thurs. a.m. HV	—	—	Mon. a.m. (monthly) ACMO/HV	—	—	—	—	—	—	—	—
Rossington St. Luke's Church Hall ...	—	Tues. p.m. GP/HV(2)	—	Tues. a.m. HV	—	—	Fri. p.m. (monthly) ACMO/HV	—	—	—	—	—	—	—	—
Rossington Dental Clinic West End Lane ...	Wed. a.m. ACMO/ HV(2) M	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Sprotborough Richmond Hill School Grounds ...	Fri. a./p.m. (alternate) ACMO/HV/ M	Wed. a.m. DMO/HV	Mon. p.m. Thurs. p.m. HV Oct.—May	Thurs. a.m. HV	—	—	Wed. p.m. (monthly) DMO/HV	—	—	—	—	—	Mon. a.m. (3rd in mth.) HMO/HV	—	—
DIV. 29. (THORNE)															
Doncaster Wood Street ...	—	—	—	—	—	—	—	—	—	—	Fri. a.m. HMO/HV	—	—	—	—
Doncaster Royal Infirmary ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	E.N.T. Wed. a.m. (2nd in mth.) HMO/HV
Dunscroft St. Edwin's Hall ...	Wed. p.m. GP/M(2)	Tues. p.m. ACMO/HV(2)	—	Tues. a.m. Thurs. a.m. HV	—	—	—	—	—	—	—	—	—	—	—
Hatfield Victoria Hall ...	—	Mon. p.m. ACMO/HV(2)	—	—	—	—	—	—	—	—	—	—	—	—	—

[illegible]

Premises	Ante-natal	Infant Welfare	U.V. Light	Minor Ailments	School	Speech Therapy	Immunisation	Child Guidance	Remedial Exercises	Mental Health	Ophthalmic	Orthopaedic	Paediatric	Dental	Other
Catcliffe Church Mission Hall ...	—	Wed. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Dalton Doncaster Road ...	Wed. p.m. GP/HV/M Thurs. p.m. (alternate) ACMO/HV/M	Tues. p.m. GP/HV	—	Tues. a.m. HV Fri. a.m. except SC, HV	Thurs. a.m. before immunisation clinic ACMO/HV	—	Fri. a.m. (1st in mth.) ACMO/HV	—	—	Mon. a./p.m. MH	3 weekly as required HMO/HV	—	—	—	—
Dinnington Methodist Chapel, Loughton Road ...	Thurs. p.m. GP/HV/M	Tues. p.m. GP/HV	—	Tues. a.m. HV Thurs. a.m. except SC, HV	Thurs. a.m. (4th in mth.) ACMO/HV	—	—	—	—	Thurs. a.m. MH	3 weekly as required HMO/HV	—	—	—	—
Kiveton Park Methodist Chapel, Wales Road ...	Thurs. p.m. (2nd in mth.) GP/HV/M	Mon. p.m. GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—
Maltby Braithwell Road...	—	—	—	—	—	—	—	—	—	—	—	—	—	Mon. a./p.m. Tue. a./p.m. Thu. a./p.m.	—
Maltby Walters Road ...	Wed. a./p.m. ACMO/HV/M	Mon. p.m. ACMO/HV	Tues. a.m. HV Fri. p.m. HV Oct.—Apl.	Tues. a.m. HV Fri. a.m. HV	Mon. a.m. (1st in mth.) ACMO/HV	—	Mon. a.m. (3rd in mth.) ACMO/HV	—	—	Tues. p.m. MH Thurs. p.m. MH	Thurs. a./p.m. 3 weekly as required HMO/HV	—	Mon. a.m. (2nd in mth.) HMO/HV	—	E.N.T. Wed. a./p.m. (1st in mth.) HMO/HV
Rotherham Hospital and Dispensary ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Swallownest Church Hall, Beighton Lane ...	Tues. a.m. (alternate) GP/HV/M	Thurs. a.m. HV Thurs. p.m. GP/HV	Tues. a.m. HV Fri. a.m. HV Oct.—Apl.	Tues. a./p.m. except SC, HV	Wed. p.m. (2nd in mth.) ACMO/HV	—	—	—	—	—	As required HMO/HV	—	—	—	—
Thurcroft Wesleyan Chapel, Woodhouse Green ...	Wed. p.m. (1st & 3rd) GP/HV/M	Mon. p.m. GP/HV	—	Mon. a.m. HV Thurs. a.m. HV	Thurs. a.m. (2nd in mth.) ACMO/HV	—	—	—	—	—	As required HMO/HV	—	—	—	—
Thurcroft Modern School ...	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Thrybergh Poplar Avenue ...	—	—	—	—	—	—	—	—	—	—	—	—	—	Daily	—
Whiston Church Institute, School Hill ...	—	Thurs. p.m. (alternate) GP/HV	—	—	—	—	—	—	—	—	—	—	—	—	—

In addition to the above there are 71 minor ailment clinics held by school nurses in the schools, chiefly at weekly intervals, and minor ailment cases are also treated at 30 centres during Infant Welfare Sessions.

NOTE :—The following abbreviations are used.

DMO.	Divisional Medical Officer.	Ps.	Psychiatrist.	ST.	Speech Therapist.
ACMO.	Assistant County Medical Officer (Senior or other).	PSW.	Psychiatric Social Worker.	MH.	Mental Health Staff.
Obst.	Joint Obstetrician (W.R.C.C. and Sheffield R.H.B.).	PSW.	Health Visitor and/or School Nurse.	Ch.	Chiroprapist.
GP.	General Practitioner.	M.	Midwife.	Relax.	Relaxation Exercise Clinic.
HMO.	Hospital Medical Officer (Consultant or Other).	ON.	Orthopaedic Nurse or Physiotherapist.	Dev.	Developmental

STAFF

(31st December, 1955)

J. Wood-Wilson, T.D., M.D., Ch.B., D.P.H.

(County Medical Officer and Principal School Medical Officer).

HEADQUARTERS

MEDICAL, DENTAL AND PROFESSIONAL

J. Leiper, M.B.E., M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.	Deputy County Medical Officer.
J. M. Anderson, M.R.C.S., L.R.C.P.	Senior Medical Officer.
A. Marshall, M.B., Ch.B.	Senior Medical Officer
J. A. Burgess, M.D., Ch.B., D.P.H.	Venereologist (Part-time).
C. C. Harvey, B.Sc., M.D., B.S., F.R.C.S., M.R.C.P.	Paediatrician (Part-time).
S. M. Leese, B.Sc., M.B., B.S., L.R.C.P., M.R.C.S., D.P.M.	Psychiatrist in Child Guidance (Part-time).
B. R. Townend, F.D.S., R.C.S.(Eng.), Dip. Orth.R.C.S.(Eng.), L.D.S.	Chief Dental Officer, Principal School Dental Officer and Orthodontic Consultant.
Vacancy	Child Guidance Psychologist.

NURSING

Miss D. Walker, S.R.N., S.C.M., H.V. Cert.	Superintendent Nursing Officer (<i>On leave of absence with World Health Organisation</i>).
Miss A. Carey, S.R.N., S.C.M., H.V. Cert., F.R.S.H.	Superintendent Health Visitor (<i>Acting Superintendent Nursing Officer</i>).
Miss R. O'Brien, S.R.N., S.C.M., H.V. Cert.	Superintendent Health Visitor.
Mrs. M. Craig, S.R.N., S.C.M. (Part 1), H.V. Cert.	Acting Superintendent Health Visitor.
Miss M. G. Edwards, S.R.N., S.C.M. (Part 1), H.V. Cert.	Health Visitor Tutor.
Miss E. M. Taylor, S.R.N., S.C.M., M.T.D.	Supervisor of Midwives.
Miss N. M. Everitt, S.R.N., S.C.M., M.T.D.	do.
Miss G. Jones, S.R.N., S.C.M., H.V. Cert., Q.I.D.N.S.	Supervisor of Home Nurses.
Mrs. W. Taylor, S.R.N., S.C.M., H.V. Cert., Q.I.D.N.S.	do.
Miss C. Bellamy, S.R.N.	Supervisor of Day Nurseries and Child Mindors.
Miss M. E. Baumann, S.R.N., S.C.M., R.M.P.A.	Nursery Nurse Tutor.
Vacancy	Chief Speech Therapist.

TECHNICAL

L. Butterworth, (1), (2), (4), (5), (10)	Chief County Sanitary Inspector.
R. D. Irving, (1), (2), (6), (8), (9)	County Sanitary Inspector.
F. C. Brookes, (1), (2)	do.

ADMINISTRATIVE AND CLERICAL

J. Colman, (1), (3), (7)	Chief Clerk.
G. Richardson, (6)	Sectional Clerk.
H. Bywater	do.
J. H. Milne, (6)	do.
R. S. Marshall	do.
H. Beatson	do.
T. R. Schofield, (6)	do.
W. J. Battyc	Senior Clerk.
A. R. Micklethwaite	do.

- (1) Sanitary Inspectors' Cert. Royal Sanitary Inst.
- (2) Cert. as Inspector of Meat and Other Foods, Royal Sanitary Inst.
- (3) Exam. in Sanitary Science as applied to Buildings and Public Works, Royal Sanitary Inst.
- (4) Final Cert. Builders' Quantities, London City and Guilds.
- (5) Final Cert. (Distinction) Builders' Quantities, Lancashire and Cheshire Inst.
- (6) Diploma in Public Administration.
- (7) Associate Chartered Inst. of Secretaries.
- (8) Sanitary Science Cert. (Liverpool University).
- (9) Cert. in advanced knowledge of Sanitary Inspectors' Duties, Royal Sanitary Inst.
- (10) Building Trades Course Certificate, Lancashire and Cheshire Inst.

DIVISIONAL MEDICAL OFFICERS

M. Hunter, M.B.E., M.D., Ch.B., D.P.H.	Division No. 1 (Skipton).
D. P. Lambert, M.D., Ch.B., D.P.H., D.T.M. & H.	„ No. 2 (Settle).
H. M. Holt, T.D., M.B., B.S. (Lond.), M.B., Ch.B. (Leeds), D.P.H.	„ No. 3 (Keighley).
J. Battersby, M.B., Ch.B., D.P.H.	„ No. 4 (Shipley).
G. P. Holderness, M.B., Ch.B., D.P.H.	„ No. 5 (Horsforth).

DIVISIONAL MEDICAL OFFICERS—continued

R. A. W. Procter, M.C., M.A., M.B., B.Chir., M.R.C.S., L.R.C.P., D.P.H., D.T.M. & H.	Division No. 6 (Otley).
N. V. Hepple, M.D., B.S., B.Hy., D.P.H.	„ No. 7 (Ripon).
D. D. Payne, M.D., B.S., M.R.C.S., L.R.C.P., D.P.H.	„ No. 8 (Harrogate).
R. G. Smithson, M.D., Ch.B., D.P.H.	„ No. 9 (Wetherby).
S. K. Appleton, M.D., Ch.B., D.P.H., D.T.M.	„ No. 10 (Goole).
J. M. Paterson, M.B., Ch.B., D.P.H.	„ No. 11 (Castleford).
J. F. Fraser, M.B., B.S., D.P.H., D.Obst.R.C.O.G.	„ No. 12 (Pontefract).
F. G. E. Hill, D.S.O., M.B., Ch.B., D.P.H.	„ No. 13 (Morley).
J. F. Caithness, M.B., Ch.B., D.P.H.	„ No. 15 (Batley).
A. L. Taylor, M.D., Ch.B., D.P.H., L.D.S.	„ No. 16 (Rothwell).
W. M. Douglas, M.B., Ch.B., D.P.H.	„ No. 17 (Spenborough).
F. Appleton, M.B., Ch.B., D.P.H.	„ No. 18 (Brighouse).
J. Lyons, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H.	„ No. 19 (Todmorden).
E. Ward, M.R.C.S., L.R.C.P., D.P.H.	„ No. 20 (Colne Valley).
J. Main Russell, M.B., Ch.B., B.Hy., D.P.H.	„ No. 22 (Wortley).
J. S. Walters, M.C., M.B., Ch.B., D.P.H.	„ No. 23 (Hemsworth).
R. S. Hynd, M.B., Ch.B., D.P.H.	„ No. 25 (Barnsley).
D. J. Cusiter, M.B., Ch.B., D.P.H., D.T.M. & H.	„ No. 26 (Wath upon Dearne).
J. Ferguson, M.B., Ch.B., D.P.H.	„ No. 27 (Adwick le Street).
A. Penman, M.B., Ch.B., D.P.H.	„ No. 28 (Doncaster).
G. Higgins, B.Sc., M.B., Ch.B., D.P.H.	„ No. 29 (Thorne).
Vacancy	„ No. 30 (Mexborough).
J. M. Watt, M.D., Ch.B., D.P.H., D.C.H., D.Obst. R.C.O.G.	„ No. 31 (Rotherham).

ASSISTANT COUNTY MEDICAL OFFICERS AND SCHOOL MEDICAL OFFICERS

C. Harris, B.A., M.B., B.Ch.	Division No. 1 (Skipton).
R. R. Stoakley, M.B., B.Ch., B.A.O.	„ No. 1 (Skipton).
N. M. E. Robertshaw, B.Sc., M.B., Ch.B., D.C.H., D.Obst. R.C.O.G.	„ No. 2 (Settle).
*B. M. Leahey, M.B., B.S.	„ No. 3 (Keighley).
D. E. Gledhill, M.B., Ch.B.	„ No. 3 (Keighley).
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J. Hayes, M.B., Ch.B.	„ No. 23 (Hemsworth).
*R. Barnes, B.A., M.R.C.S., L.R.C.P., D.P.H.	„ No. 25 (Barnsley).
S. G. A. Henriques, M.B., Ch.B.	„ No. 25 (Barnsley).

ASSISTANT COUNTY MEDICAL OFFICERS AND SCHOOL MEDICAL OFFICERS—continued

M. R. Menzies, M.B., Ch.B., D.C.H. ....	.....	.....	Division No. 26 (Wath upon Dearne).
A. Kropacz, L.R.C.P., L.R.C.S. ....	.....	.....	„ No. 27 (Adwick le Street).
M. T. Burton, B.A., L.M.S.S.A., L.M. ....	.....	.....	„ No. 28 (Doncaster).
C. M. Dornan, M.B., B.Ch., B.A.O. ....	.....	.....	„ No. 28 (Doncaster).
R. B. Laidlaw-Becker, M.D., Ch.B., M.R.C.S., L.R.C.P., D.P.H., D.P.M. ....	.....	.....	„ No. 29 (Thorne).
*B. R. A. Demaine, M.B., Ch.B., D.P.H. ....	.....	.....	„ No. 30 (Mexborough).
H. F. Lindsay, M.B., Ch.B. ....	.....	.....	„ No. 30 (Mexborough).
*A. P. Gorrie, M.B., Ch.B. ....	.....	.....	„ No. 31 (Rotherham).
M. J. Hallinan, M.R.C.S., L.R.C.P. ....	.....	.....	„ No. 31 (Rotherham).
J. Lodwick, B.A., M.B., B.Ch. ....	.....	.....	„ No. 31 (Rotherham).

111 General Medical Practitioners who act as Child Welfare Centre Medical Officers and are employed on a sessional basis. This is the equivalent of 14.66 whole-time Assistant County Medical Officers.

*Senior Assistant County Medical Officer and School Medical Officer.

OBSTETRICIAN (Joint Appointment with Hospital Services)

J. C. MacWilliam, L.R.C.P., L.R.C.S., L.R.F.P. & S., D.Obst. R.C.O.G.

CHEST PHYSICIANS (Joint appointments with Hospital Services)**SHEFFIELD REGION**

D. H. Anderson, V.R.D., M.D., B.Ch., B.A.O., D.P.H.
H. A. Crowther, M.A., M.R.C.S., L.R.C.P.
F. C. N. Holden, M.D., B.S., M.R.C.S., L.R.C.P.
A. C. Morrison, M.D., Ch.B., D.P.H.

LEEDS REGION

R. G. Benians, M.A., M.D., B.Chir., M.R.C.P.
J. G. Cairns, M.B., Ch.B., D.P.H.
D. J. Charley, M.D., B.S., M.R.C.P., M.R.C.S.
J. A. Dick, M.B., Ch.B.
R. S. Donaldson, M.D., Ch.B., D.T.M., D.P.H.
P. A. Duke, M.D., Ch.B., D.P.H.
G. F. Edwards, M.B.E., M.B., B.S., M.R.C.S., M.R.C.P.
H. Grunwald, M.D. (Vienna).
W. D. Hamilton, M.B., B.Ch., B.A.O., D.P.H.
G. Henry, M.B., B.Ch., B.A.O.
D. A. Herd, L.R.C.P., L.R.C.S., L.R.F.P. and S.
J. W. Jordan, M.D., B.S., M.R.C.S., M.R.C.P.
B. T. Mann, B.Sc., M.D., Ch.B., D.P.H.
M. S. Oxley, M.B., Ch.B., T.D.D.
H. E. Raeburn, M.D., B.S., L.M.S.S.A., D.P.H.
A. D. Rankin, M.B., Ch.B., D.P.H.
V. Ryan, M.D., B.Ch., B.A.O., D.P.H.
J. K. Scott, M.B., Ch.B., M.R.C.P., D.P.H.
D. K. Stevenson, M.B., Ch.B., M.R.C.P.
J. Viner, M.B., Ch.B.
R. N. Walker, M.D., Ch.B., D.P.H.
A. Weleminsky, M.D. (Prague).
S. P. Wilson, M.Sc., M.D., Ch.B., D.P.H.

OTHER SPECIALIST STAFF

There are 65 Ophthalmic, 17 Ear, Nose and Throat, 18 Orthopaedic, 5 Paediatric, 1 Dermatological and 1 Cardiac clinics, the service of consultants or Senior Hospital Medical Staff being supplied by either the Regional Hospital Boards or Leeds University.

ORTHODONTIC SPECIALIST

R. Sclare, L.D.S.

SENIOR DENTAL OFFICERS

J. M. Enderby, L.D.S.
O. A. Long, L.D.S.

SCHOOL DENTAL OFFICERS

I. F. Ash, B.Ch.D.	E. Millward, L.D.S.
W. J. Brown, L.D.S.	S. Mitchinson, L.D.S.
G. H. Bulcock, L.D.S.	D. B. Owen, L.D.S.
F. W. Buzza, L.D.S.	M. H. Platford, L.D.S.
B. C. Clay, L.D.S.	D. G. Rennie, L.D.S.
K. R. Cowell, L.D.S.	F. H. Sanderson, L.D.S.
J. M. Davison, L.D.S.	S. S. Sanderson, L.D.S.
W. H. Dyke, L.D.S.	B. Sleight, B.Ch.D.
J. K. Ellwood, B.Ch.D.	H. Taylor, L.D.S.
P. F. A. Eltome, L.D.S.	C. F. Tehan, B.D.S.
J. D. Franks, L.D.S.	M. M. Thom, L.D.S.
M. M. Gibson, L.D.S.	G. A. Thompson, B.Ch.D.
M. Hattan, L.D.S.	E. Thornton, L.D.S.
S. Henry, L.D.S.	P. W. Thornton, L.D.S.
A. M. Holburn, L.D.S.	J. Todd, L.D.S.
F. Kershaw, L.D.S.	B. Watts.
S. Levinson, L.D.S.	G. O. Wood, L.D.S.
F. Lister.	H. M. Yuile, L.D.S.
E. S. Midgley, L.D.S.	

12 Part-time.

DENTAL LABORATORY

J. O. Ford, Senior Dental Technician.
 9 Senior Technicians.
 2 Boy Dental Apprentices.

HEALTH VISITORS, MIDWIVES, MEDICAL AUXILIARIES, etc.

6 Divisional Superintendent Health Visitors.
 310 Health Visitors and School Nurses.
 7 Orthopaedic Nurses and Physiotherapists (three part-time).
 1 Psychiatric Social Worker.
 14 Tuberculosis Visitors.
 287 Home Nurses and Home Nurse Midwives.
 192 Midwives.
 1,681 Domestic Helps (19 whole-time and 1,662 part-time).
 4 Venereal Diseases Social Workers (Qualified Health Visitors).
 8 Speech Therapists.
 1 Chiropodist (Part-time).
 1 Supervisor of Mental Health Occupation Centres and Home Teachers (vacancy).
 15 Mental Health Social Workers.
 22 Mental Health Home Teachers (2 part-time).
 48 Dental Attendants.

COUNTY ANALYST (part-time)

R. Mallinder, B.Sc., F.R.I.C.
 J. C. Harrel, F.R.I.C. (Deputy).

DAY NURSERIES

8 Day Nurseries — total nursing staff 44.

MENTAL HEALTH OCCUPATION CENTRES

Castleford.	Staff—1 Supervisor; 3 Assistant Supervisors or Nursery Assistants.
Keighley.	Staff—1 Supervisor; 3 Assistant Supervisors or Nursery Assistants.
Hemsworth.	Staff—1 Supervisor; 2 Assistant Supervisors or Nursery Assistants.

INDEX

	<i>Page.</i>
Ambulance Services	60
Analgesia in Childbirth	54
Ante-natal Services	45, 46
Atmospheric Pollution	87-92
Relationship between Deaths from Certain Causes and Atmospheric Pollution	15, 16
Births and Infant Mortality	8-10
Births, Premature	49-51
Blind and Partially Sighted Persons, Certification and Treatment of	106
Care and Attention, Removal of Persons in need of	107, 108
Child Guidance	121, 122, 137
Child Mortality	17, 18
Children's Specialist, Work of	128-130
Cleansing, Public	95
Clinics, List of	142-164
Closet Accommodation	95
County Children's Homes and Residential Nurseries, Medical Arrangements for	108
Day Nurseries	51
Deaths and Death Rates	8-19
Dental Service	45, 47, 130-132, 138
Diphtheria, Incidence, Immunisation	22, 59
Divisional Administration of the Preventive Medical Services	38-43
Drainage and Sewerage	97-99
Dysentery	27-30
Ear, Nose and Throat Consultant Service	124
Encephalitis, Acute	27
Enteric (Typhoid) Fever	32
Environmental Hygiene	84-104
Epidemiology	20-37
Epileptic and Spastic, Welfare of the	105
Expectant and Nursing Mothers, Dental Treatment of	46, 47
"Flying Squad" Arrangements, domiciliary midwifery	55
Food and Drugs Acts, 1938-50	103, 104
Food Poisoning	33
Handicapped Child, Care of the	115-123, 138
Health Centres	45
Health Education	69, 70
Health Visiting	55-57
Home Helps	73-75
Home Nursing	57-59
Homes for Disabled and Old Persons, Registration and Inspection of	106, 107
Housing	92-95
Ice-Cream	86, 87
Illegitimate Children	9, 48, 49
Infant Mortality	8-10
Infant Welfare Centres	47, 48
Infectious Disease, Notification and Incidence of	20, 21
Influenza	33
Liaison with the Hospital Service	70, 71
Maternal Mortality	18, 19
Measles	23
Meningococcal Infection	23
Mental Health	65, 66, 76-83
Midwifery	52-55
Milk—	
Milk (Special Designation) (Pasteurised and Sterilised Milk) Regulations, 1949-53	84
Sampling from Hospital Farms	85
Specified Areas for the Sale of Milk	85, 86
Supply to School Children	86

INDEX—*continued*

	<i>Page.</i>
Mothers and Young Children, Care of	45-51
National Health Service Acts	45-83
Nuisance Inspections	100
Nurseries, Day	51
Nursery and Child-Minders Regulation Act, 1948	108
Nursing Equipment in the Home, Provision of	71-73
Nursing Homes, Registration of	108, 109
Ophthalmia Neonatorum	30
Ophthalmic Service, School	123
Orthopaedic Service	124
Paediatric Service	124
Paratyphoid Fever	32
Physical Features	7
Poliomyelitis, Acute	23-27
Post-natal Services	46
Premature Babies	49-51
Prevention of Damage by Pests Act, 1949	100
Prevention of Illness, Care and After-Care	60-73
Puerperal Pyrexia	30
Recuperative Home Treatment	71
Residential Nurseries and County Children's Homes, Medical Arrangements for	108
Rural Water Supplies and Sewerage Acts, 1944 to 1955	100-102
Sanitary Circumstances	92-102
Sanitary Inspectors, Summary of Visits and Other Duties	102
Scarlet Fever	21
School Child, Health of the	111-141
School Children—	
Cleanliness	125
Medical Inspection and Treatment	112-115, 123-125, 133-138
Nutrition	126
School Nursing	125
Sewerage and Drainage	97-99
Smallpox	30-32
Smoke Abatement	92
Spastic and Epileptic, Welfare of the	105
Staff, List of	165-168
Staff, Medical Examination of County	110
Swimming Baths and Pools	100
Tuberculosis—	
B.C.G. Vaccination	62, 63
Care and After-Care	60-65
Deaths from	8, 34-36
Institutional Accommodation	37
Mass Radiography	63-65
Notification of Cases	34-37
Protection of School Children against	62, 63, 127, 128, 140
Vaccination and Immunisation	21, 22, 30-32, 59
Vaccination against Smallpox	30-32, 59
Venereal Diseases	66-68
Vital Statistics	7-19
Water Supplies	95-97
Welfare Foods, Distribution of	48
Whooping Cough, Incidence, Immunisation	21, 22, 59
Youth Employment Service	126